UnitedHealthcare Insurance Company

Questions, Complaints/Grievances and Appeals

Questions Regarding your Benefits

Questions regarding your Benefits should be directed to:

UnitedHealthcare Insurance Company
P.O. Box 30573
Salt Lake City, UT 84130-0573

Or the telephone number shown on your ID card. If you do not have your ID card, please contact us at 866-414-1959.

If you need the assistance of the governmental agency that regulates insurance, or you have a complaint that you have been unable to resolve with us, you may contact the Department of Insurance by mail, telephone or e-mail at:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204
Consumer Hotline: 1-800-622-4461 or 1-317-232-2395
Complaints may be filed electronically at www.in.gov/idoi

You may designate a representative to handle your complaint on your behalf. Please note that all references made to "you" in this section, include you and/or your designated representative.
You may go to www.in.gov/idoi to view internal and external grievance information developed by the Indiana Department of Insurance, including the process that you should follow in filing an internal or external grievance and a telephone number for the Department of Insurance where you may call to obtain additional information.

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

What if You Have a Question?

Call the telephone number shown on your ID card. If you do not have your ID card, please contact us at 866-414-1959. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint/Grievance?

Call the telephone number shown on your ID card. If you do not have your ID card, please contact us at 866-414-1959. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint/grievance to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit an oral or written complaint/grievance. We will notify you that we have received your complaint/grievance within five business days. We will notify you of our decision regarding your complaint/grievance within 20 business days after receiving all needed information from you. If for reasons beyond our control we are

unable to make our decision, we will notify you before the 20th business day, and complete the review within 10 additional business days. We will notify you within five business days after we have made our decision. This notification will include:

- A statement of the decision reached by us;
- A statement of the reasons, policies, and procedures that are the basis of the decision;
- Notice of your right to appeal the decision; and
- The department, address, and telephone number through which you may contact a qualified representative to obtain additional information about the decision or the right to appeal.

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

Your request for an appeal should include:

- The patient's name and the identification number from the 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.

How to Appeal all other Complaint/Grievance Decisions

If you disagree with either any complaint/grievance determination other than those described under *How Do You Appeal a Claim Decision?* above, you can contact us orally or in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The reason you disagree with the determination.
- Any documentation or other written information to support your request.

Your first appeal request must be submitted to us within 180 days after you receive our decision on your complaint/grievance.

Appeal Process

We will respond to oral and written appeals of complaint/grievance decisions by providing written or oral acknowledgement of the appeal not more than five business days after the appeal is filed.

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and

the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits, Post-service Claim and any other Complaint/Grievance Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims and any other complaint/grievance as defined above, the appeal will take place and you will be notified of the decision within 45 days from receipt of a request for appeal.

Please note that our decision for pre-service requests for benefits and post-services claims are based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights are described below under the *External Review* provision and will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could 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 72 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 of the decision by the end of the next business day following receipt of the required information.

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

External Review

You may request an external review on a final determination to a complaint/grievance. You must request an external review within 120 days after receiving notification of our decision.

We are responsible for selecting an independent review organization from the list of independent review organizations that are certified by the State of Indiana Department of Insurance. A different independent review organization must be selected for each external review and we will not repeat a selection until all independent review organizations have been used. You are permitted to request only one external review per complaint/grievance.

The independent review organization has 15 business days to determine whether to uphold or reverse our final determination, or 72 hours, if the seriousness of your condition warrants an expedited external review. Once the independent review organization has made their determination, they will notify you and us of their determination as follows:

- within 72 hours after making the determination for a standard external grievance; or
- within 72 hours after the external grievance is filed for an expedited external grievance.

The external review program may not be available if our coverage determinations are based on Benefit exclusions or defined Benefit limits. Additionally, if you have the right to an external review of a grievance under Medicare, you may not request an external review of the same grievance under this Policy.

If at any time during the external review process, you submit information to us that is relevant to our final determination that was not considered during the initial review, we will reconsider our decision. The independent review organization will cease the external review until the reconsideration is complete.

We will reconsider our decision based on the new information and notify you within 15 business days, or three business days, if the seriousness of your condition warrants an expedited review, after this new information is submitted.

If after considering the new information, our final determination is still to deny benefits, you may request that independent review organization resume the external review.

If you are still not satisfied with our decision, you have the right to take your complaint to the State of Indiana Department of Insurance.