Welcome to the Bind Provider Guide

This Provider Guide is intended to help you better understand the Bind innovative approach to health insurance, answer key questions that you or your patients may have, and provide details on the processes and systems that need to be established in order to prepare for Bind members and process claims.

Multiple functions across your organization have a role to play in ensuring your systems are properly set up.

We will lead you through the process step by step, which will ultimately help avoid confusion and potential delays in claims handling and processing.

We’ve made this document easy to navigate as each department can skip ahead to what they need to know just by clicking on the links.

Let’s jump in.
About Bind

Bind is a health plan that’s easy, personal and flexible.

As an affiliate of UnitedHealthcare (UHC), Bind accesses their provider contracts as well as provider contracts for a few other network partners. The Bind plan includes in-network preventive care; primary and specialty care; urgent, emergency and hospital care; chronic care for long-term and recurring illnesses; and pharmacy. Members pay a copay/member price (Bind members may refer to copays as prices) for services received under the Bind plan.

There is no deductible or coinsurance. Copay/member price amounts are available to the member in advance for any in-network visit through the MyBind.com or Bind Help Team.

Providers will be able to check eligibility or view copay/member price amounts using the same methods they use to verify benefits and copay/member price amounts today—through the provider portal or by calling the provider services number on a member’s ID card. There is additional information on the following pages on how to check member eligibility and benefits.

NOTE! The Bind plan members must activate coverage for approximately 45 plannable, non-emergency treatments, when and if they need them, at least three business days in advance of receiving the treatment or they will not have coverage.

For example, members can activate coverage for a knee replacement when they actually need it, as long as they activate coverage three business days in advance of the treatment. The list of the applicable treatments for coverages available with activation may vary based on the customer and the plan year. A sample list is available in the frequently asked questions section of this document.

Federal law (the Employee Retirement Income Security Act of 1974, or ERISA) exempts self-funded plans established by private employers from most state insurance laws, including reserve requirements, mandated benefits and consumer protection regulations.
Your experience with Bind will be familiar in some ways, but different in others. Many of those differences will benefit you. We’ll help you navigate Bind so your organization knows what to expect and can prepare for Bind members and claims.

Here’s what you need to know:

- Bind primarily leverages UHC networks for medical (usually the Choice Plus network) and Optum Behavioral Health network. These network contracts govern payments by Bind. While Bind leverages the UHC provider network and some of its systems, UHC and Optum maintain their own relationships with providers.

- Bind also works through other networks in certain states. Review the back of each member’s ID card to determine the network:
  - In Michigan for one client (Ascension), Bind accesses the SmartHealth network as well.
  - In Minnesota, PreferredOne network (through 2020) is used for three clients.

- Bind uses certain UHC services like the UMR provider portal for benefits and eligibility, and the UMR provider service line.

- In most instances, prior authorizations and advance notifications are the same as with UHC plans.

- Bind follows the UHC Provider Administration Guide and policies, while the Bind Provider Guide is included as a supplement with Bind exceptions (e.g., prior authorization, coverages available with activation).
What you need to know

Membership

While Bind leverages the UHC provider network, people are considered Bind members and must present a Bind member ID card.

Providers need to confirm the member has active coverage.

A small set of non-emergency, plannable treatments require the member activate coverage at least three business days in advance of the treatment. Refer to page 17 for more details.

Prior authorization

Bind has two different processes:

- Prior authorization and admission notification requirements apply as outlined by existing UHC provider guidelines for all services in the Bind plan.

- Coverages available with activation do NOT require prior authorization, but provider should confirm activation of coverage.

What's different about Bind

How Bind works with UHC and Optum

Tracking the patient journey through the revenue cycle
What you need to know

How Bind works with UHC and Optum

What's different about Bind

Tracking the patient journey through the revenue cycle

Copays/member prices vary.

Certain procedures have an increased specificity in pricing. We can better match what our plans pay for services with the value those services provide by creating more precise benefit categories and then setting prices for those categories. In addition, we can decide to apply our pricing approach to the providers offering the service. Then, we can price the individual service/provider pairs according to the health value they deliver.

You can verify the copay/member price by using the methods on the ID card: either the UMR provider portal or provider services phone number.

Pricing can vary within a provider location.

The copay/member price can be different for varying doctors or practitioners within the same practice. For example, a member goes to Dr. Martinez for an office visit, and the copay/member price is $15. The next visit the member goes to Dr. Waverly and the copay/member price is $30.
Pricing can vary by service location.

The copay/member price can be different between varying locations. For example, an MRI at W. Lake St. in Minneapolis may have a copay/member price of $150, while the location down the street may have a copay/member price of $375.

Costs are periodically updated.

Prices may change as practice patterns and outcomes change. There is no charge to you, the provider, but the patient may pay a different amount.

- Providers will always need to check what copay/member price to collect for the service/treatment.
- The provider total payment does NOT change. It will always be the contracted rate.
To avoid extra steps that slow down processes and create inefficiencies, it’s important to know which systems you’re accessing.

In the sections that follow, we’ll lead you through a step-by-step process for each department, so you know exactly where to go and what the set-up is.

Ready to get started? Let’s go.
Getting set up

**FUNCTION**

- Add the Bind Benefits, Inc., payer ID number into your systems; this is a critical step to avoid delays in registration, claims handling, processing and more.
- Bind Benefits, Inc., is the payer ID: 25463. Bind Benefits, Inc., may be entered as the “insurance” carrier (dependent on provider processing system).
- This payer ID may be attached to multiple networks. Examples include:
  - UHC networks
  - PreferredOne network (through 2020)
  - SmartHealth network
- Refer to the member ID card for the specific network accessed by the member.

What does the member ID card look like for Bind?

Each member ID card may look different depending on the employer and where the member lives.

**Claims column**—provides the payer ID and claim mailing address.

**Networks column**—provides the network and provider resources. For some members, the network accessed will depend on the location of the provider.

*Sample member ID cards for illustration only; actual information varies depending on payer, plan and other requirements.*
Getting set up

FUNCTION

Load the Bind payer ID

Check eligibility

Determine benefits and coverage

Check prior authorization / admission notification

Submit claims

- Ensure the patient is an enrolled member with Bind for the date of service.

- When checking eligibility and benefits using the UMR provider portal or UMR provider service phone number, you must search under subscriber information, then identify the dependent.

- Use an Eligibility and Benefit Inquiry (270) transaction to inquire about the health care eligibility and benefits associated with a subscriber or dependent. Some systems may need to enter the mnemonic “Bind.”

- Please take note of the subscriber number in addition to dependent number. Subscriber number is used for eligibility and benefit checks in the portal and phone number, as well as claims submission.
Determine benefits and coverage.

Some Bind members can activate coverage when their health needs change. Verify the member has coverage for the procedures prior to scheduling, as members may activate coverage for these procedures at any point in the plan year (at least three business days in advance of the covered treatment or service). Activated coverage is specific to the member, provider and place of service.

For UnitedHealthcare networks

If the member ID card references the UHC Choice Plus network or other UHC networks, refer to the UHSS provider portal, UHSS.UMR.com or call the provider services number listed on the member ID card.

Optum Behavioral Health network applies for behavioral health services.

When checking eligibility and benefits, you’ll need to search by the subscriber name or ID. All covered dependents will then show under the subscriber name.
For SmartHealth networks

If the member ID card references the SmartHealth network, refer to the website on the card, YourBind.com/SmartHealth, or call the number listed on the card. You may also check eligibility using EDI 270/271 inquiry for eligibility and benefits.

Providers will need to check what copay/member price (from the provider portal or provider service phone number) to collect for the service or treatment, as certain copays/member prices are dynamic and may vary by location and by practitioner.

For PreferredOne networks

If the member ID card references a PreferredOne network, refer to the PreferredOne provider portal, preferredone.com/providers, or call the number listed on the member ID card.

Getting set up

FUNCTION

Load the Bind payer ID

Check eligibility

Determine benefits and coverage

Check prior authorization / admission notification

Submit claims

Ready to start collecting payments?
Getting set up

FUNCTION

Check eligibility

Determine benefits and coverage

Check prior authorization / admission notification

Submit claims

Check prior authorization and admission notification requirements.

Prior authorization and admission notification requirements for Bind are the same for the network the member is accessing. Bind has contracted with UHC Clinical Services to perform this function. Providers should contact 1-877-237-0006 for prior authorizations and admission notifications.

How do I know if flexible coverage exists?

Plans with flexible coverage do NOT require prior authorization. However, if the coverage is expected to be performed in the inpatient setting, pre-admission notification is required.

While prior authorization is not required for flexible coverage in the outpatient setting, providers are highly encouraged to check eligibility in advance of the procedure to verify their patient has activated the coverage.

Participating providers may receive a lack of coverage notification for medically necessary procedures typically covered by other health plans when that procedure is a Bind coverage available with activation procedure.

If that happens, this indicates a member has not yet activated coverage for the procedure. Members are required to activate coverage at least three business days prior to the procedure being performed. If coverage is not activated, the related claims will be denied with member responsibility.

Understand our policy on prior authorizations?
Getting set up

Your checklist:

- Ensure claims are going to Bind: use the correct payer ID and mailing address.
- Always include the rendering address on the claim if different than billing. This is used to confirm the copay/member price. If not included, the copay/member price may be incorrect from what the member/provider was originally quoted.
- For procedures for which a member activates coverage, we utilize the codes that you provide to help members purchase coverage for these procedures. If there is a change, it impacts the member’s purchase, so you must alert Bind if planned changes occur.
- Claims are paid based on contracted TINs per the network partner contracts, so providers should manage adds, terms or changes through UHC in a timely fashion to ensure that payment occurs appropriately.

Submit claims with subscriber information. If a claim is for a dependent, include the dependent’s name.

Electronic submission to the
Bind payer ID: 25463

All claims should be routed to
Bind Benefits, Inc., following the instructions on the member ID card.
Bind Benefits, Inc.
PO Box 211758
Eagan, MN 55121

Ready to start submitting claims?
Frequently asked questions

How is pricing determined?

Bind members can look up copays/member prices for services on the MyBind app or at MyBind.com. Copays/member prices may vary based on location or practitioner.

Practitioners and locations that are at a lower copay/member price charge less for their services and/or were identified as providing more efficient and effective care.

The copay/member price does not impact payment to providers; payment is based on the applicable network contract (in this case, UHC Choice Plus).

Will we need to be credentialed with Bind?

Separate credentialing is not required for providers credentialed with the network accessed by the member. For example, UHC manages the credentialing for the UHC networks.

How do I know if I am a participating provider or location?

Providers or locations that participate (and contract) with the network accessed by the member seeking care (e.g., UHC Choice Plus) are participating providers and locations for Bind members.

If we are set up for ERAs and EFTs with UHC, do we need to do anything?

No. If your system is already set up to receive ERAs and EFTs, you need not do anything more to receive payment for services provided to Bind members.
Frequently asked questions

At what rates will we be paid? Will all this affect our fee schedule?
Payment is set according to the network contract you have in place. The copay/member price displayed to members does not affect the active fee schedule.

If a patient activates coverage for a treatment — obtains that treatment—but then requires additional care, how are charges handled for the follow-up treatments? Example: post hip replacement, member sees the orthopedic surgeon in a follow-up appointment or physical therapy.
Additional services following the procedure are covered and member is charged the appropriate copay/member price provided to Bind members. In the example, the physical therapy or office visit copay/member price would apply for the follow-up visit.

How would an emergency visit in which there hasn’t been time to activate coverage be handled?
If a procedure occurs within an emergency encounter, activation of coverage is not required for eligible Bind members.

I don’t see any vision or dental related flexible coverages. Is there vision coverage on the Bind plan, either routine or medical?
Member benefits can vary by employer, so we encourage providers to verify benefits on the provider portal or via the provider phone line.
Frequently asked questions

What treatments require coverage activation prior to treatment by the member?

Bind separates a small set of less common, non-emergency, plannable treatments few people need annually, if at all. Coverage for these treatments and services is available but inactive unless members choose to activate it—and members must activate the coverage at least three business days in advance of the covered treatment or service. See a sample list below. Each employer may have a different list, so please consult the member’s specific benefits.

**Flexible coverages list**

*Note: List is sample only and may vary based on customer and plan year.*

<table>
<thead>
<tr>
<th>Musculoskeletal (23)</th>
<th>Cardiovascular (6)</th>
<th>ENT (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ankle and Foot Bone Fusion</td>
<td>• Cardiac Ablation</td>
<td>• Ear Tubes</td>
</tr>
<tr>
<td>• Ankle Arthroscopy and Ligament Repair</td>
<td>• Carotid Endarterectomy and Stents</td>
<td>• Sinus and Nasal Septum Surgery</td>
</tr>
<tr>
<td>• Ankle Replacement and Revision</td>
<td>• Coronary Artery Bypass Graft Surgery</td>
<td>• Tonsillectomy and Adenoidectomy</td>
</tr>
<tr>
<td>• Bunionection and Hammertoe Surgery</td>
<td>• Coronary Catheterization and Percutaneous Coronary Interventions</td>
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<tr>
<td>• Carpel Tunnel Surgery</td>
<td>• Pacemakers and Defibrillators</td>
<td></td>
</tr>
<tr>
<td>• Cervical Spine Disc Decompression</td>
<td>• Valve Replacement</td>
<td></td>
</tr>
<tr>
<td>• Cervical Spine Fusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Elbow Arthroscopy and Tenotomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Elbow Replacement and Revision</td>
<td></td>
<td></td>
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<tr>
<td>• Ganglion Cyst Surgery</td>
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<td></td>
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<tr>
<td>• Hip Arthroscopy and Repair</td>
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<tr>
<td>• Hip Replacement and Revision</td>
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<tr>
<td>• Knee Arthroscopy and Repair</td>
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<td>• Knee Replacement and Revision</td>
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<tr>
<td>• Lumbar Spine Disc Decompression</td>
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<td>• Lumbar Spine Fusion</td>
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<tr>
<td>• Morton’s Neuroma Surgery</td>
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<tr>
<td>• Plantar Fasciitis Surgery</td>
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<tr>
<td>• Shoulder Arthroscopy and Repair</td>
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<td>• Shoulder Replacement and Revision</td>
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<tr>
<td>• Spinal Cord Stimulator</td>
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<tr>
<td>• Wrist and Hand Joint Replacement</td>
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<tr>
<td>• Wrist Arthroscopy and Repair</td>
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</tr>
</tbody>
</table>

**Gastrointestinal (5)**

• Bariatric Surgery
• Gallbladder Removal Surgery (Cholecystectomy)
• Hernia Repair
• Reflux and Hiatal Hernia Surgery
• Upper GI Endoscopy
Frequently asked questions

What types of services are included in flexible coverage?

<table>
<thead>
<tr>
<th>Knee Replacement and Revision Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service covered by:</td>
</tr>
<tr>
<td>Preoperative visit</td>
</tr>
<tr>
<td>Anesthesia and procedure-specific medications</td>
</tr>
<tr>
<td>Treatment-date facility fees</td>
</tr>
<tr>
<td>Knee surgery replacement service</td>
</tr>
<tr>
<td>Postoperative visit</td>
</tr>
</tbody>
</table>

*Kopays/member prices

Are there medical policies that need to be followed to indicate medical necessity?

Bind follows medical necessity and utilization management guidelines from the UHC Provider Administration Guide.

Are referrals required for a member to see a specialist?

Referrals are not required for Bind members.
Frequently asked questions

Where do I send claims?
All claims should be routed to Bind Benefits, Inc., following the instructions on the member ID card.
Electronic claims to: 25463
Paper claims to: Bind Benefits, Inc., PO Box 211758 Eagan, MN 55121

Why do copays/member prices change within the plan year?
Bind uses the UHC Choice Plus network, along with historical data, to assign prices and reflect up-to-date understanding of the value of treatment a provider offers.

Why do prices vary?
With clear pricing that reflects value, Bind members can choose their most effective and efficient paths to health, possibly paying less along the way.
The amount of the copay/member price does not impact payment to providers; payment is based on the applicable network contract.
Bind assigns lower member cost to locations that manage patient conditions efficiently. Locations with lower member cost are likely to have lower complication/readmission rates, be efficient in care delivery, have robust post-procedure coordination processes and charge competitive rates for the care provided. This is based on three years of data from each distinct rendering location.

Why are some of our practitioners priced differently within the same practice?
Bind uses the UHC Choice Plus network, along with historical data, to assign prices and reflect up-to-date understanding of the value of treatment a provider offers. Practitioners (physician, nurse practitioner, etc.) are evaluated against peers within the practitioner’s specialty or sub-specialty, if applicable.
Frequently asked questions

How do I change my price?
Price changes are based on performance data. Bind uses the UHC Choice Plus network, along with historical data, to assign prices and reflect up-to-date understanding of the value of treatment a provider offers.

When do I call Bind versus using the portal?
Providers may call the provider service phone number on the member ID card for benefits and eligibility, or if they are unable to find the information they need from the provider portal or 271 response.

What if we want a different copay/member price—can decisions be reconsidered?
Copay/member price ranges are ultimately the decision of the plan sponsor. Bind cannot change the copay/member price range. Within the range, Bind is not able to modify copay/member prices at this time. Bind will evaluate scenarios such as a provider location moving from one address to another and billing from the same tax ID.

Where do I check claims status?
For UHC network, call UMR provider services or check on UHSS.UMR.com.
Frequently asked questions

Where do provider appeals/disputes go?
For UHC network, refer to the number on the back of the member ID card.

Is there a way to see how facilities and physicians rank in comparison to others?
Currently, there is no way to see how facilities and physicians rank.

Can you tell me how many members are in my state? Region? City?
Please contact your UHC provider advocate for this information.

Still don’t have the answers?
Get in touch.