UnitedHealthcare Exchange Plans

Frequently Asked Questions

Overview

UnitedHealthcare Exchange benefit plans are built on patient-centered care, with the goal of enhancing the patient-doctor relationship and promoting better health and lower costs. Exchange plans place the focus on primary care, with members assigned a primary care provider (PCP) to help them manage their health care needs.

Key Points

- UnitedHealthcare Exchange plans utilize a customized, more focused network of care providers.
- Members are assigned a PCP within the service area to help manage their health care needs.
- The member's PCP must submit electronic referrals for members to see a network specialist physician. Specialists must be located within the defined service area.
- Standard prior authorization and notification requirements apply.

UnitedHealthcare Benefit Plans for Exchanges

State	Plan Names	PCP Required	Referral Required	Prior Authorization Required	Out-of-Network/ Out-of-Area Coverage
Arizona	Value Gold Value Plus Silver Value Silver Value Bronze	Yes	Yes	Yes	No*
Maryland	Value Gold Balance Gold Value Silver Balance Silver Value Bronze Balance Bronze	Yes	Yes	Yes	No*

United Healthcare

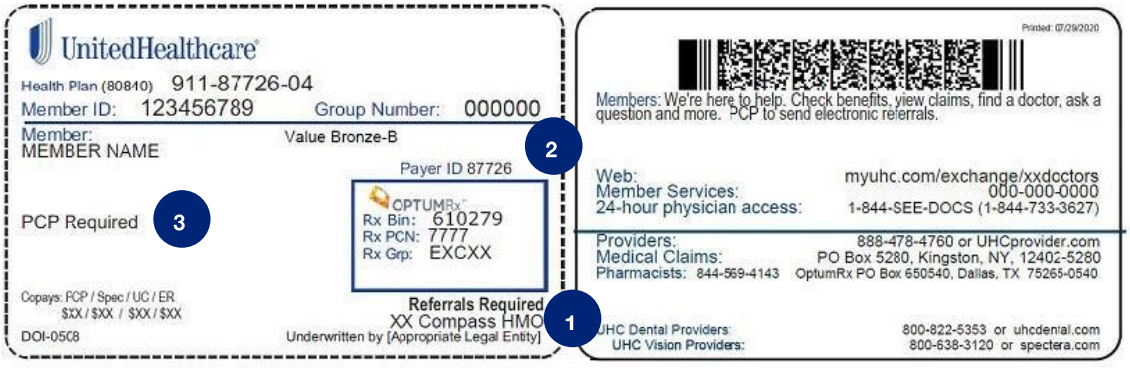
North Carolina	Balance Gold Balance Plus Silver Balance Silver Value Silver Balance Bronze Value Bronze	Yes	Yes	Yes	No*
Oklahoma	Value Gold Value Silver Balance Plus Silver Balance Bronze Value Bronze	Yes	Yes	Yes	No*
Tennessee	Value Gold Balance Plus Silver Balance Silver Value Silver Value Bronze Saver Balance bronze	Yes	Yes, for the member to have coverage	Yes	No*
Virginia	Value Gold Balance Silver Balance Plus Silver Value Silver Balance Bronze Value Bronze	Yes	Yes, for the member to have coverage	Yes	No*
Washington	Cascade Select Gold Cascade Select Silver Cascade Select Bronze	Yes	Yes, for the member to have coverage	Yes	No*

* *Except for emergency services and related authorized admissions.*

Sample Member ID Card

Look for key differences on the member's ID card to identify plan type and benefit features:

1. Name of state exchange with referral indicator
2. Payer ID number
3. PCP information or "PCP Required"; find the member's assigned PCP by using the eligibilityLink tool on Link. Sign in at **UHCprovider.com/eligibilityLink**.



Sample member ID card for illustration only. Actual information may vary.

United Healthcare Exchange Plans

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Member Coverage

When does benefit coverage begin?

Members are required to pay the first month's premium before coverage goes into effect. To identify whether a member is in the grace period, you can check their eligibility at UHCprovider.com/eligibilityLink. If a member has not paid their premium during the second or third month, claims will pend until payment is received. The member may not be billed during this time. If the premium is paid, the claims will be released for payment. If the premium is not paid by the end of the third month, the claims will be denied. The grace period starts over each time the member defaults on their premium.

The Patient Protection and Affordable Care Act (ACA) requires health insurers to provide a three-month grace period before terminating coverage for members who have not paid their premiums. The grace period applies to those who received an advanced premium tax credit and have paid at least one full month's premium within the benefit year.

Provider Network

Do UnitedHealthcare Exchange benefit plans use the same network as UnitedHealthcare Choice/Choice Plus?

No. UnitedHealthcare Exchange plans utilize a customized, more focused network to better meet our members' needs. To find network care providers, including hospitals and independent labs, please refer to the provider directory at UHCprovider.com/findprovider.

How do I know if I'm in network for Exchange benefit plans?

Care providers participating in UnitedHealthcare commercial benefit plans may already participate in benefit plans offered on the Exchange, unless the network is listed as an excluded benefit plan in your Participation Agreement. Participating care providers must have a location in the network service area to be eligible for in-network coverage. Locations listed outside of the service area may not be considered eligible for in-network coverage.

Participating care providers agree to give UnitedHealthcare members equal access to the treatment they need. This includes delivery of service(s) or treatment for any member of an Exchange plan that the provider participates in.

PCPs

What is the role of the PCP for Exchange benefit plans?

PCPs oversee their patients' care and actively manage referrals to network specialists. The PCP helps guide their patients along the best care path so they can get the care they need. All Exchange members will be assigned a PCP.

Where can I find a list of members assigned to my practice?

You can generate a PCP roster report using the Document Vault tool on Link. To learn more about Document Vault and access the tool, go to UHCprovider.com/documentvault.

How do members choose a PCP?

Members are assigned a PCP upon enrollment. Each family member may have a different PCP, depending on their needs. Subscribers and all dependents must have an assigned PCP in the market in which the subscriber lives or works. Once a PCP is assigned, both the care provider and member can view the PCP online. The PCP name **will not** be listed on the member's ID card. You can view the member's assigned PCP using the eligibilityLink tool at UHCprovider.com/eligibilityLink.

Can members change their PCP?

Yes. Members may request to change their designated PCP by calling the Customer Care number on their ID card or by submitting a PCP change request at myuhc.com. Members can make changes once per month. These changes are effective the first of the month.

If a PCP practices at more than one location, does it matter which location the member visits?

Members are required to see their assigned PCP at a location that is within the defined service area. If the assigned PCP is not available, members may also see a covering physician at the address location that shares the same tax ID number (TIN) as the member's assigned PCP. Some PCPs have multiple TINs. Please note that the PCP may not be participating for the Exchange benefit plans at locations with a different TIN.

Specialist Referral Requirement

Who is responsible for generating referrals?

The member's assigned PCP or a PCP within the same TIN are the only care providers allowed to submit referrals. If the PCP doesn't follow the electronic referral requirements, the Exchange member will have no coverage. The specialist must also be in network and within the defined service area.

Which services do not require a referral?

The following services do not require a referral:

- PCPs within the same tax ID as the member's assigned PCP. Please note that specialists within the same TIN as the member's assigned PCP require referrals.
- Network obstetricians/gynecologists, including perinatologists
- Network urgent care centers or convenience clinics
- Routine refractive eye exams from a network provider
- Mental health disorders/substance use from network behavioral health clinicians
- Pathologists, radiologists or anesthesiologists
- Emergency room or emergency ambulance
- Physician for emergency/unscheduled admissions
- Network, facility-based inpatient/outpatient consulting physicians, assisting surgeons, co-surgeons or team surgeons
- Non-physician services, including but not limited to, durable medical equipment, home health, prosthetic devices, hearing aids, outpatient lab, X-ray or diagnostics, physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation services, cardiac rehabilitation services, post cochlear implant aural therapy, cognitive rehab – **with the exception** of manipulative treatment and vision therapy (e.g., physician services). Services performed by a specialist will require a referral.
- Other network services for which applicable laws do not require a referral

Can members seek care outside the state in which they live?

It's important to note that Exchange members have **no benefit coverage for services provided outside the network of participating providers, and they do not have benefit coverage for services provided outside the defined service area**, except for emergency services and related authorized admissions, unless specifically approved by UnitedHealthcare. To be covered, members must receive eligible services at participating provider locations within the limited service area. The defined service area for your state is listed in the Overview document included in this Welcome Kit or can be found in the Provider Administrative Guide located at **UHCprovider.com/guides**.

How many visits are included with each referral to a specialist?

Referrals can be backdated up to five days prior to the date of entry. Each referral is valid for up to six months, or six visits, whichever is met first. Unused visits expire six months from the referral start date. After the six visits are used or expire, the PCP may submit another referral to the network specialist for up to six visits.

Can I view referrals online?

Yes. You may securely view a member's referrals using the referralLink tool on Link, available at UHCprovider.com/referralLink. Information includes the network specialist the member is referred to, number of authorized visits and number of visits remaining.

Do specialists and facilities have to confirm a referral is on file from the member's PCP before seeing the member?

Yes. Specialists must confirm a referral is on file before seeing the member since Exchange plans have no benefit if a referral is not obtained.

Facilities should also confirm the referral is on file for the member to see the admitting specialist for planned admissions. If the member doesn't have a referral, the facility and specialist claims will be denied for no referral if the member has a UnitedHealthcare Exchange plan.

Is a new referral needed if a member needs to see another specialist, return for additional visits after the referral has expired or all visits have been used?

Yes. In each case, the member's PCP must be contacted to consider an additional referral.

Referral Submission Requirements

How do PCPs submit specialist referrals?

The member's PCP must submit an electronic referral using the referralLink tool on Link or through EDI278R transactions before a member can see the network specialist. To use the referralLink tool, go to UHCprovider.com/referralLink. The referral is effective immediately and will be viewable online within 48 hours.

Referrals will not be accepted by phone, fax or paper, unless required by state law. Referrals may be entered on Link with a referral start date up to five calendar days prior to the date of entry. For more information about referrals, go to UHCprovider.com/referrals.

Does my office staff need security access to submit and view referrals?

Yes. If you've assigned the pre-defined role type, "All Transactions on UHCprovider.com and Link" for your staff, they'll have access to submit and view referrals for members. If your practice has customized roles, be sure the appropriate staff members in your practice have the "Referral Submission Role." For more information on access and roles, go to UHCprovider.com/Link > Getting Started With Link.

Advance Notification/Prior Authorization

Do Exchange health plans require advance notification or prior authorization?

Advance notification and prior authorization are required for certain planned services so we can determine if the services are covered under the member's benefits. Prior authorization is granted only for services determined to be medically necessary according to the member's benefit plan and applicable policies and guidelines. It's the physician's responsibility to follow the advance notification or prior authorization procedures as outlined at **UHCprovider.com/exchanges** > Exchange Plans Advanced Notification/Prior Authorization Requirements. Additional information for Exchange plans can be found in the Health Insurance Marketplace (Exchanges) Supplement to the Provider Administrative Guide, available at UHCprovider.com/guides.

Is admission notification required?

Yes. Admission notification is required for every inpatient admission. The admission notification requirement applies even if a referral or prior authorization is on file. Admission notification is the hospital's responsibility, as outlined in the UnitedHealthcare Administrative Guide.

Member Billing

Can members be billed for non-covered services?

Yes. According to the terms of your Participation Agreement, you may bill members for non-covered services under certain circumstances, unless otherwise required by state law.

For example, while joint replacements are generally covered benefits, a medical necessity review may determine a particular joint replacement for a member isn't covered. If the services you provide aren't covered under the member's benefit plan for reason of not being medically necessary, you may bill the member only if they've been informed of the decision of non-coverage prior to the date of the service and have specifically agreed **in writing** to accept financial responsibility. The written agreement must indicate the member understands UnitedHealthcare has determined the service is non-covered, and the member chooses to receive the service and be financially responsible for payment.

Resources

What if I have additional questions about these health plans?

If you have question, please call Provider Services at **888-478-4760** or go to UHCprovider.com/exchanges. Information is also available in the UnitedHealthcare Administrative Guide. To access the Administrative Guide, go to UHCprovider.com/guides.

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