Optum

Frequently Asked Questions

2027 UnitedHealthcare Individual Exchange Plans

UnitedHealthcare is expanding options during the 2027 open enrollment period for members to purchase health insurance using a Health Insurance Marketplace, otherwise known as an Individual Exchange. These plans are marketed as Individual and Family Plans (IFP), and the Marketplace may be referred to as Individual Exchange (IEX).

These Frequently Asked Questions provide additional details about the Exchange plans and outline key processes providers should follow.

Member Coverage

When does benefit coverage begin?
Members are required to pay the first month's premium before coverage goes into effect.

The Patient Protection and Affordable Care Act (ACA) requires health insurers to provide a 3-month grace period before terminating coverage for people who have not paid their premiums. Here's what you need to know about the grace period.

- **Grace period eligibility:** 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.
- **Claim status:** Lack of premium payment affects claim status and processing:
  - If a member has not paid their premium during the second or third month, claims will be pending 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.
- **Grace period reset:** The grace period starts over each time the member defaults on their premium.

How will I know if a member is in a grace period?
There are 3 ways to verify if the member is in a grace period:

1. **EDI 271 Response Transactions –** Will return the following information:
   - **Coverage Status**
     - 1st month: Active
     - 2nd month: Active – Pending Investigation
     - 3rd month: Active – Pending Investigation
   - **Period Start** – First day of the first month of the grace period
   - **Period End** – Last day of the third month of the grace period
   - **MSG – Individual Exchange Grace Period**
     - If the service date is one month after the claim 'eligible-through' date, the member is in the second grace period month.

2. **UnitedHealthcare Provider Portal –** The secure provider portal also includes an information icon message where the user can hover to understand what each period means to them and the member. The portal will indicate if the member is within a grace period and in what month of the grace period.
3. **Contact UnitedHealthcare –** Verify member eligibility by calling **1-888-478-4760**.

Provider Network

Does Optum Behavioral Health use the same network for UnitedHealthcare Individual Exchange Benefit Plans that is used for Optum Commercial business?

No. UnitedHealthcare Individual Exchange Plans use a customized, focused network to better meet consumer needs around access to quality and efficient care for local communities. To find network providers, please refer to the Live and Work Well online provider directory.(Password: clinician)

How do I know if I'm in-network for the Individual Exchange Benefit Plans?

Providers who participate in the UnitedHealthcare Commercial plan network may already participate for benefit plans offered on the Individual Exchange.

- Providers **must have a location in the network service area** to be eligible to participate in the Individual Exchange network.
- Locations listed outside the service area may not be eligible for the Individual Exchange network.

Participating providers agree to give UnitedHealthcare members equal access to the treatment they need. This includes delivery of service(s) or treatment(s) for any Individual Exchange member covered by health plans that a provider participates in.

How to identify your IFP state(s) and program(s)

You can verify which IFP state(s) and program(s) you participate in through the Provider Express secure portal.

1. Log in to the Provider Express secure portal with your One Healthcare ID and password
2. Select **My Practice Info**. Then choose **My Networks**.
   - If you are participating in the IFP exchange, your Network ID will include the State and Exchange
   - To be reimbursed for ABA services for IFP exchange members, ABA must appear in your Exchange network ID name
   - Network IDs without ABA are for non-ABA behavioral health services

Advance Notification/Prior Authorization

Do Exchange health plans require advance notification or prior authorization?

Advance notification and/or prior authorization are required for certain planned services so Optum Behavioral Health can determine if the service(s) are covered under the member's health plan.

- Prior authorization is granted only for services determined to be medically necessary according to the member's health plan, as well as applicable UnitedHealthcare and Optum Behavioral Health policies and guidelines.
- Providers are responsible for following the UnitedHealthcare advance notification or prior authorization procedures as outlined in the UnitedHealthcare Provider Administrative Guide. Additional information is available in the Prior Authorization section of providerexpress.com.

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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 facility's responsibility.

How do Optum Behavioral Health providers obtain prior authorization for members covered through UnitedHealthcare Individual Exchange Benefit Plans?
Prior authorizations requests should be submitted online through the Provider Express secure portal.

- Log in to the Provider Express secure portal with your One Healthcare ID and password
- **Individual providers and groups (Outpatient requests):** Select **Auths** > **Auth Request**. Enter the required information and submit.
- **Facilities (Higher Levels of Care):** Select **Auths > Review Online.** Enter the required information and submit.

Member Billing

Can members be billed for non-covered services?
According to the terms of your Participation Agreement (contract), you may bill members for non-covered services under certain circumstances.

Specifically, if you request prior authorization for behavioral health service(s) or for continued treatment **and** UnitedHealthcare does not authorize the requested services. In that circumstance, you may bill the member if they have signed a written statement after the non-coverage determination but before the service(s) are rendered. The signed statement must include language indicating:

1. That you have informed the member that we UnitedHealthcare was unable to authorize such services for coverage under the member's health plan
2. The reason given by UnitedHealthcare for not authorizing the services; and
3. As a result, the member has been denied coverage for such services under their benefit plan and will be financially responsible

Member Benefits

Do members have out-of-network benefits?
Individual Exchange plan members do not have an out-of-network benefit. They are required to use a provider from the customized, more focused Individual Exchange network.

How do I verify a member's eligibility and benefits?
You can use the UnitedHealthcare Provider Portal to verify your network participation in the member's health plan. It's important to check the member's eligibility and benefits before providing care. Health plans and coverage can change within a single enrollment year. When checking eligibility, be sure you:

1. Verify your network participation in the member's health plan
2. Confirm whether the member is in the plan's grace period.
3. Know the member's financial liabilities at the time of service.

Claims

How do Optum Behavioral Health providers submit claims for members covered through

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UnitedHealthcare Individual Exchange Benefit Plans?

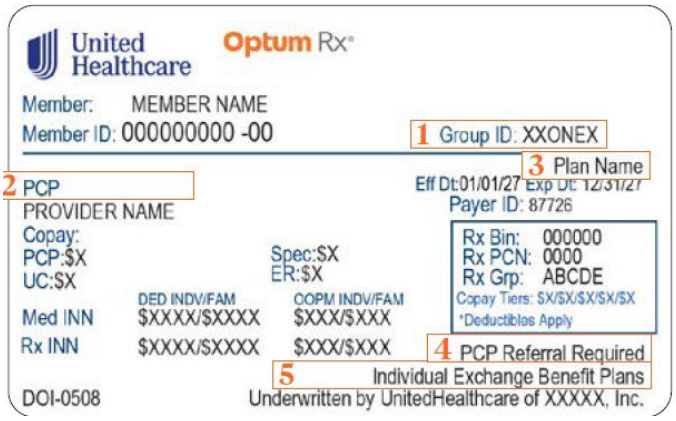
EDI	UnitedHealthcare Provider Portal	By mail
Electronic Data Interchange (EDI) is the most automated way to submit claims. The member's ID card will indicate the Payer ID to use for EDI claim submissions. Get more information on EDI.	You can also submit claims electronically through the UnitedHealthcare Provider Portal. Learn how.	UnitedHealthcare P.O. Box 5280 Kingston, NY 12402

Sample UnitedHealthcare Individual Exchange Member ID Cards

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

- Name of state exchange
- Payer ID used for electronic data interchange
- Primary Care Provider information or "PCP Required" reference
- Referral required indicator (if applicable)
- Member's network name
- Referral requirement statement (if applicable)
- Claims mailing address

Individual Exchange plan member cards





Sample member ID cards for illustration only. Actual information varies depending on payer, plan and other requirements. Member Services, physician, and mental health phone numbers will be populated with the state-specific phone number(s).

Front

1. **Group ID**
2. **PCP** Member's primary care physician
3. **Plan Name**
4. **PCP** Indicates if referrals are required (if applicable by the plan)
5. **Individual Exchange Benefit Plans** Indicates that the plan is an Exchange plan

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Kelsey-Seybold Individual Exchange plan member cards



Sample member ID cards for illustration only. Actual information varies depending on payer, plan and other requirements. Member Services, physician, and mental health phone numbers will be populated with the state-specific phone number(s).

Front

1. **Plan name and Kelsey-Seybold Clinic logo**
2. **Payer ID** – Claims must be submitted to Payer ID KELSE
3. **PCP Required indicator** – All members will be auto-assigned to Kelsey-Seybold Clinic
4. Indicates if referrals are required (if applicable by the plan)

Back

5. Kelsey-Seybold appointment scheduling number

Sanitas Narrow Network Individual Exchange plans in Arizona, Florida and Texas

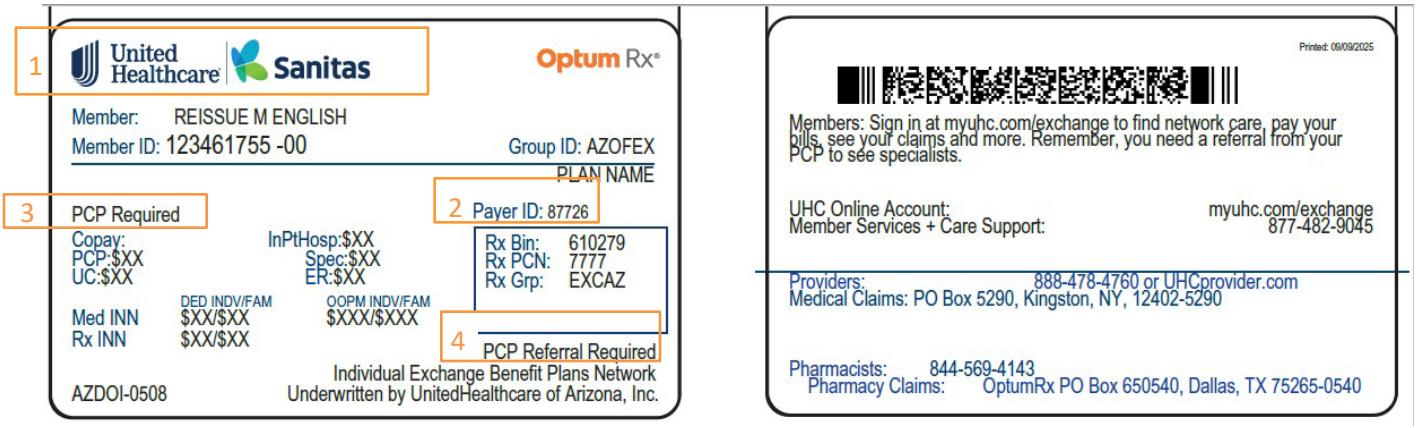
In 2027, we're offering Individual Exchange plans using a capitated, narrow network anchored by Sanitas Medical Centers to members in the following areas:

- San Antonio and Houston areas (Bexar and Fort Bend) in Texas
- Phoenix, AZ area (Maricopa County)
- Miami, FL area (Broward, Miami-Dade and Palm Beach counties)

Members who select these plans will be assigned to a Sanitas Medical Center primary care provider and receive custom member ID cards. Not a Sanitas network participating provider? Please redirect members to a Sanitas medical center.

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Sanitas Individual Exchange plan member cards



Sample member ID cards for illustration only. Actual information varies depending on payer, plan and other requirements. Member Services, physician, and mental health phone numbers will be populated with the state-specific phone number(s).

Front

1. **Plan name and Sanitas logo**
2. **Payer ID** – Submit claims to Payer ID 87726
3. **PCP Required indicator** – All members will be auto-assigned to Sanitas
4. Indicates if referrals are required (if applicable by the plan)

Questions?

- You can find state-specific materials and resource information at Individual Exchange Plan Information for Providers
- For additional questions, please contact your Provider Advocate or Provider Services at **1-877-614-0484,** Monday – Friday, 7 a.m. – 7 p.m. CT.
  - Not sure who your Advocate is? Go to Contact Us > Provider Services and select your state to find contact information.

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