2025 UnitedHealthcare Individual Exchange Plans

Overview

In 2025, UnitedHealthcare is expanding options for members to purchase health insurance using a Health Insurance Marketplace, otherwise known as an Individual Exchange. These plans are marketed as Commercial Individual and Family Plans (IFP), and the Marketplace may be referred to as Individual Exchange (IEX).

These Frequently Asked Questions provide additional detail 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 three-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 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.
- **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.
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, more 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.

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 a health plans that a provider participates in.

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 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 UHCProvider.com.

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 Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal. Use the same One Healthcare ID and password you established for the Optum Behavioral Health Provider Express secure portal.

Member Billing

Can members be billed for non-covered services?
Yes, 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 signed 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. That, 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 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. More information	You can submit up to 20 claims at a time through the secure portal. Learn how	UnitedHealthcare P.O. Box 5280 Kingston, NY 12402

Questions?

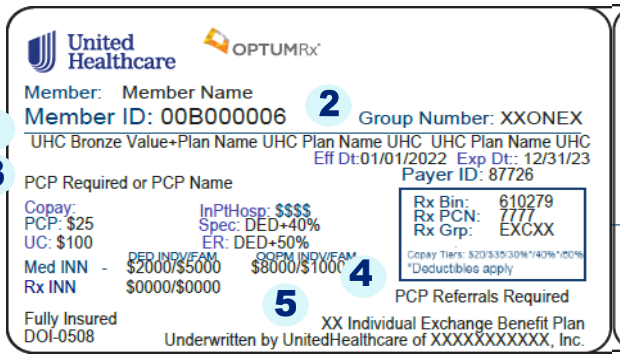
More information can be found at UHCProvider.com/Exchanges. You may also contact Optum Behavioral Health Provider Services at **1-877-614-0484**.

Sample UnitedHealthcare Individual Exchange Member ID Card

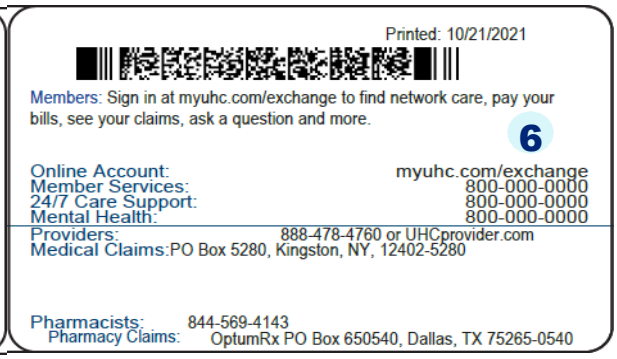
Look for key differences on the member's ID card to identify plan type and benefit features:

- 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

Front

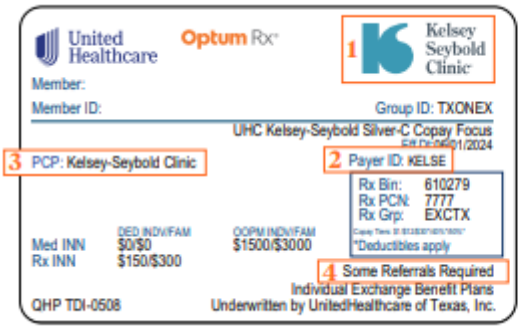


Back



1. **Plan name** – includes the metal level (Bronze, Silver, Gold, Platinum)
2. **Group number** – ONEX = plans offered on the Exchange / OFEX = plans offered off the Exchange
3. **PCP name, "PCP Required" or blank**
4. Indicates if referrals are required (if applicable by the plan)
5. Member's network name
6. The word "exchange" in this web address indicates an Exchange plan

How to identify a member with a Kelsey-Seybold Individual Exchange plan



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)
5. Kelsey-Seybold appointment scheduling number

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).