UnitedHealthcare Core

Frequently Asked Questions

Overview

UnitedHealthcare Core is an open-access commercial member benefit plan that features a customized, narrow network of care providers. The two plan options within the Core suite – Core and Core Essential – offer varying levels of coverage and plan designs to help meet our members' needs.

Plan models	Benefits	Provider referrals	Out-of-network
Core Essential	Core network providers only	Not applicable	No coverage*
Core	Core network and non-network providers	Not applicable	Lower benefits

**Except for emergency services and related admissions*

Frequently Asked Questions

Provider Network

How do I know if I'm a network care provider for Core benefit plans?

If you participate in other UnitedHealthcare commercial benefit plans, you're considered a network care provider for UnitedHealthcare Core and Core Essential, unless these plans are specifically excluded in your Participation Agreement. If Core and Core Essential aren't excluded plans, you'll be listed in our Core provider directory.

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Do Core and Core Essential use the same network as UnitedHealthcare Choice/Choice Plus?

No. UnitedHealthcare Core and Core Essential feature a customized, narrow network to better meet our members' needs.

What is the difference between Core and Core Essential?

Core Essential includes network-only benefits. There are no benefits for services from non-network care providers, except for emergency services. Core includes a higher level of benefits for services from Core network care providers and a lower level of non-network benefits for services from non-network care providers.

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Do UnitedHealthcare Core and Core Essential require a referral?

No, these plans do not require referrals. Core and Core Essential members can seek care from any Core network care provider without a referral and without designating a PCP.

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

Yes. Core and Core Essential members have access to the national network of Core providers. To find a Core network provider, go to **UHCprovider.com/findprovider**.

What if a member requires care that isn't available from a Core network specialist or facility?

If you feel care is not available for a particular member in the Core network, please follow the prior authorization process outlined in the UnitedHealthcare Administrative Guide. To obtain prior approval for a member to receive care from a non-network care provider, submit a request by calling the number on the back of the member's health plan ID card. We'll review the request and determine which network care providers are available. If approved, we'll apply the network benefits to the services performed by the non-network care provider. We will mail our decision to the requesting care provider and the member.

Before submitting a request for non-network care, please confirm there isn't a network care provider available by searching the Core provider directory, available at **UHCprovider.com/findprovider**. For members who have the W500 Additional Network Benefit, check the W500 Emergent Wrap directory.

What is the W500 Additional Network Benefit?

Some benefit plans include additional network benefits for certain services provided through an alternate care provider network. These services include:

- Emergency services and related admissions bullet
- Urgent care
- Services pre-approved by UnitedHealthcare when services aren't available from a network physician

The W500 Additional Network Benefit plan consists of UnitedHealthcare providers who are otherwise excluded from participation in the member's plan.

Advance Notification/Prior Authorization

Do these plans require advance notification/prior authorization for services?

Advance notification/prior authorization are required for some services. Prior authorization is granted only for services determined to be medically necessary, according to the member's benefit plan and applicable policies and guidelines. Advance notification/prior authorization policies and procedures are outlined in the Notification Requirements section of the UnitedHealthcare Administrative Guide, located at **UHCprovider.com/guides**. Information about prior authorization is also available at **UHCprovider.com/priorauth**.

Is admission notification required?

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

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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. For example, while joint replacements are generally covered benefits, a medical necessity review may determine that 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.

What if I have questions about these plans?

If you have questions, please contact Provider Services at 877-842-3210 or go to **UHCprovider.com/plans** > State > Commercial > UnitedHealthcare Core.

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