Understanding Transition of Care and Continuity of Care

Transition of Care

Transition of Care gives new UnitedHealthcare Level Funded plan participants the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time due to a specific medical condition until the safe transfer to a network health care professional can be arranged. Examples of covered medical conditions can be found on Page 2 of this document. You must apply for Transition of Care no later than 30 days after the date your UnitedHealthcare coverage begins using the form beginning on Page 4.

Continuity of Care

Continuity of Care gives UnitedHealthcare Level Funded plan participants the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network. Plan participants with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at network rates for specific medical conditions for a defined period of time.

Get help with understanding these health insurance terms and more on Page 3.

Examples of covered medical conditions can be found on Page 2 of this document

If your health care professional is leaving the UnitedHealthcare network, or if you are a new UnitedHealthcare Level Funded plan participant, you must apply for Continuity of Care or Transition of Care within 30 days of the health care professional's termination date or within 30 days of your effective date, using the form beginning on Page 4.

continued

How Transition of Care and Continuity of Care works

You must already be under active and current treatment (see definition below) by the identified non-contracted health care professional for the condition identified on the Transition of Care and Continuity of Care form below.

Your request will be evaluated based on applicable Federal law, plan benefits and accreditation standards. Coverage at the network level is available if the provider agrees to accept our network rates, provide medical records, follow our policies and a treatment plan approved by us.

- If your request is approved for the medical condition(s) listed in your form(s), you will receive the network level of coverage for treatment of the specific condition(s) by the health care professional for:
  - Up to 30 days from the effective date of coverage for new plan participants,
  - Up to 90 days from when your provider leaves your health plan network, or
  - Through completion of the current active course of treatment period, whichever comes first
- If your request is received after the above time-frames, you will not be eligible for Transition of Care or Continuity of Care
- After this time, network coverage ends. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the time frame we approve, you must follow your plan's out-of-network requirements, including any prior authorization or notification requirements.
- All other services or supplies must be provided by a network health care professional for you to receive network coverage levels
- If your plan does not include out-of-network coverage, you can call the number on the back of your health plan ID card for assistance
- The availability of Transition of Care and Continuity of Care coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. Depending on the actual request, a medical necessity determination and formal prior authorization may still be required for a service to be covered.

Examples of medical conditions that may qualify for Transition of Care and Continuity of Care includes, but is not limited to:

- Pregnant and undergoing a course of treatment for pregnancy
  - Coverage for newborn children begins at the moment of birth and continues for 30 days. You must select an in network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.
- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant
- Recent major surgeries in the acute phase and follow-up period (generally six to eight weeks after surgery)
- Serious acute conditions in active treatment such as heart attacks or strokes
- Other serious chronic conditions that require active treatment

Examples of conditions that do not qualify for Transition of Care and Continuity of Care include:

- Routine exams, vaccinations and health assessments
- Chronic conditions such as diabetes, arthritis, allergies, asthma, kidney disease and hypertension that are stable
- Minor illnesses such as colds, sore throats and ear infections
- Elective scheduled surgeries

Frequently asked questions

What can I expect after the completed form is submitted?

You will receive a written decision either approving or denying your request. We encourage you to find a doctor, health care professional or facility (like a hospital) in your network at **myuhc.com®.**

If I am approved for Transition of Care and Continuity of Care for one medical condition, can I receive network coverage for a non-related condition?

No. Network coverage levels provided as part of Transition of Care and Continuity of Care are for the specific medical conditions only and cannot be applied to another condition. If you are seeking network level of benefits for more than one medical condition, you will need to complete a separate request for each specific condition.

Definitions	
Transition of Care	Gives new Level Funded plan participants the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time due to a specific medical condition, until the safe transfer to a network health care professional can be arranged.
Continuity of Care	Gives plan participants the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network.
Network	The facilities, providers and suppliers your health plan has contracted with to provide health care services.
Out-of-network	Services provided by a non-participating provider.
Pre-authorization	An assessment for coverage under your health plan before you can get access to medicine or services.
Active course of treatment	An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment plan. Discontinuing an active course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with recovery. Generally an active course of treatment is defined as within the last 30 days, but is evaluated on a case-by-case basis.

See other health care and health insurance terms and definitions at justplainclear.com.

Transition of Care and Continuity of Care Form

This form is for Level Funded plan participants only.

For behavioral health services, please fax the completed form to 1-877-867-4129 or contact the Customer Service phone number on your health plan ID card.

To complete this form:

- Please make sure all fields are completed. When the form is complete, it must be signed by the plan participant for whom the Transition of Care and Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.
- You must complete and submit the form for Transition of Care and Continuity of Care within 30 days of the effective date of coverage or within 30 days of the care provider's termination date
- A separate Transition of Care and Continuity of Care form must be completed for each condition for which you and/or your dependents are seeking Transition of Care and Continuity of Care
- Please mail or fax the completed form along with relevant medical records and information, within 30 days following the effective date of your UnitedHealthcare plan to:

  UnitedHealthcare Level Funded
  600 Airborne Parkway
  Cheektowaga, NY 14225
  Attn: Transition of Care/Continuity of Care
  Fax: 877-867-4129

- After receiving your request, UnitedHealthcare will review and evaluate the information provided. Incomplete forms will be returned to the requestor. If the form is complete, we will send you a letter to let you know if your request was approved or denied. Completion of this form does not guarantee that a Transition of Care and Continuity of Care request will be granted.

Plan participant information		
☐ New Level Funded plan participant (Transition of Care applicant) ☐ Existing Level Funded plan participant whose care provider terminated (Continuity of Care applicant)		Provider termination date
Name (person being treated)	Plan participant ID number	Date of birth (mm/dd/yyyy)
Address	City	State/ZIP Code
Home/cell phone number		Work phone number
Plan sponsor name		Date of enrollment in the Level Funded Plan (mm/dd/yyyy)
Relationship to plan participant ☐ Self ☐ Spouse ☐ Dependent ☐ Other	Is the plan participant currently covered by other health insurance carrier? ☐ Yes ☐ No If yes, carrier name:	
Authorization to release records: I authorize all physicians and other health care professionals or facilities to provide UnitedHealthcare information concerning medical care, advice, treatment or supplies for the plan participant named above. This information will be used to determine the plan participant's eligibility for Transition of Care/Continuity of Care benefits under the plan.		
Plan participant's signature/parent or guardian's signature		Date (mm/dd/yyyy)

Care provider section: Your health care professional should complete the following information		
Name (treating physician or other healthcare professional)	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone number
Address	City	State/ZIP Code
Facility name, NPI or TIN, city and state		Facility phone number
Date of last visit (mm/dd/yyyy)	Next scheduled appointment (mm/dd/yyyy)	Frequency of visits
Diagnosis	Expected length of treatment	If maternity: Expected date of delivery (mm/dd/yyyy)

Please select 1 of the descriptions if it applies:

☐ Life-threatening condition ☐ Acute condition ☐ Transplant ☐ Inpatient/confined

☐ Upcoming surgery ☐ Disabled/disability ☐ Terminal illness ☐ Ongoing treatment

Newborn plan participants: Coverage for newborn children begins at the moment of birth and continues for 30 days. You must select a network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.

Is the treatment for an exacerbation of a previous injury or chronic condition? ☐ Yes ☐ No

Current condition and associated treatment plan (include brief statement and all relevant CPT codes)*
If these care needs are not associated with the condition for which you are requesting Transition of Care and Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care form for each condition.

We understand you are not, or soon will not be, a participating provider in our network. Our plan participant is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the plan participant is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the plan participant's plan, for the applicable time-frame, (2) follow our policies and procedures, (3) upon request, share information regarding the plan participant's treatment with us, (4) if applicable, make referrals for services, including laboratory services to network providers, or ask for our approval before referring a plan participant to an out-of-network provider, and (5) if applicable, request any required prior approval before the services are rendered. Please note the following:

For providers leaving our network: The terms and conditions of your participation agreement will continue to apply to the covered service, including any follow-up care covered under the plan participant's plan. Payment under your participation agreement, along with any co-payment, deductible or coinsurance for which the plan participant is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the plan participant, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

For out-of-network providers seeing new plan participants: If the plan participant is eligible, we will provide coverage at the network benefit level. Payment will be consistent with the plan participant's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from us along with any co-payment, deductible or coinsurance for which the plan participant is responsible under the plan as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the plan participant, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of health care professional	Date (mm/dd/yyyy)

*Attached additional clinical as needed.

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