UnitedHealthcare Transition of Care

California

Understanding Transition of Care and Continuity of Care.

Transition of Care

Transition of Care gives UnitedHealthcare members the option to request extended coverage for care from their current, out-of-network health care professional for a limited time, due to a specific medical condition, until the safe transfer to a network health care professional can be arranged. For Transition of Care under the California Insurance Code, a member's out-of-network may be paid at a higher reimbursement level. The member is responsible for the difference between the reimbursement amount and the out-of-network provider billed amount in addition to the member's deductible or coinsurance. Examples of covered medical conditions can be found on page 2 of this document. You must submit your request for Transition of Care no later than 30 days after the date your UnitedHealthcare coverage begins, using the form beginning on page 5. Submissions received after 30 days will be reviewed on a case-by-case basis.

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

Continuity of Care

Continuity of Care gives UnitedHealthcare members 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. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at benefit and cost-sharing levels associated with in-network providers and network rates for specific medical conditions for a defined period of time. Submissions received after 30 days will be reviewed on a case-by-case basis.

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

If your health care professional is leaving the UnitedHealthcare network, you must submit a request for Continuity of Care within 30 days of the health care professional's termination date using the form beginning on page 5.

UnitedHealthcare®

How Transition of Care and Continuity of Care works:

You must already be under active and current treatment (see definition on page 4) by the identified non-contracted health care professional for the condition identified on the Transition of Care and Continuity form below.

- A formal determination must be made by UnitedHealthcare that a change to a network health care professional would have a negative effect on your health. Your request will be evaluated based on applicable state law and accreditation standards.
- If your request is approved for the medical condition(s) listed in your form(s), you will receive coverage for treatment of the specific condition(s) by the health care professional until:
    - The member's condition under Transition of Care or Continuity of Care is medically stable; and
    - There are no medical conditions or concerns that would prevent a safe transfer to a network health care professional. This is determined by UnitedHealthcare in consultation with your treating out-of-network health care provider and, if applicable, your assigned network health care professional.

  All other services or supplies must be provided by a network health care professional for you to receive network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving care beyond the time frame approved by UnitedHealthcare, you must follow your plan's out-of-network requirements, including pre-authorization requirements.
- The availability of Transition of Care or 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 in order for a service to be covered.

Examples of medical conditions that may qualify for Transition of Care and Continuity of Care:

- Pregnancy for the duration of the pregnancy through six weeks post-delivery.
    - 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.
- Newborn care for a child between birth and age 36 months. Coverage under Transition of Care or Continuity of Care will not exceed 12 months from the provider's agreement termination date or the newly enrolled member's effective date. Coverage will also not extend beyond the child's third (3rd) birthday.
- 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.
- Surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract’s termination date or within 180 days of the effective date of coverage for a newly covered enrollee.
- Serious acute conditions in active treatment, such as heart attacks or strokes. Completion of covered services will be provided for the duration of the acute condition.
- Other serious chronic conditions that require active treatment.
- Treatment for a terminal illness, an incurable or irreversible condition that has a high probability of causing death within one (1) year. Completion of covered services will be provided for the duration of the illness.
- Behavioral health and substance abuse care for a reasonable period of time to safely transition care to a network health care professional. This includes:
    - Behavioral health care received from a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker. For behavioral health and substance abuse services, please contact your behavioral health and substance abuse carrier by calling the customer service phone number in your enrollment information or on your health care ID card.
    - Maternal mental health condition received from a treating health care provider. Completion of covered health care services for the maternal mental health condition shall not exceed 12 months from the diagnosis or form the end of the pregnancy, whichever occurs later.

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

- Routine exams, vaccinations and health assessments.
- Chronic conditions that are stable (except as required by state law).
- Minor illnesses such as colds, sore throats and ear infections.
- Care for any condition that exceeds 12 months beyond the provider's termination date or your effective date of coverage. This limit does not apply to Continuity of Care for terminal illness.

Frequently asked questions:

Q **If my application is approved, how long will I have to transition to a new network health care professional?**

A If UnitedHealthcare determines that transitioning to a participating health care professional is not recommended or safe for the conditions that qualify for Transition of Care and Continuity of Care, services by the approved out-of-network health care professional will be authorized for a specified period of time, or until care has been completed or transitioned to a participating health care professional, whichever comes first. You must submit a request for Transition of Care or Continuity of Care within 30 days of the effective date of coverage or within 30 days of the care provider's termination date, or you may not be eligible for the Transition of Care or Continuity of Care service. Submissions received after 30 days will be reviewed on a case-by-case basis.

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

A No. Network coverage levels provided as part of Transition of Care and Continuity of Care are for specific medical conditions only and cannot be applied to another condition. If you are seeking Transition of Care or Continuity of Care coverage for more than one medical condition, you should complete a Transition of Care/ Continuity of Care Form for each specfiic condition.

Definitions:

Transition of Care: Gives new UnitedHealthcare members the option to request extended coverage from their current, out-of-network health care professional 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 UnitedHealthcare members 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.

Maternal Mental Health Condition: A mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one (1) year after delivery.

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 all fully insured members in California.

To complete this form:

- Please make sure all fields are completed.
- When the form is complete, it must be signed by the member for whom the Transition of Care or Continuity of Care is being requested. If the member is a minor, a guardian's signature is required.
- You must submit a request for Transition of Care or Continuity of Care within 30 days of the effective date of coverage or within 30 days of the care provider's termination date. Forms received after 30 days will be reviewed on a case-by-case basis.
- 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 or 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
  600 Airborne Parkway
  Cheektowaga, NY 14225

  Attn: Transition of Care/Continuity of Care
  Fax: 1(855) 686 - 3561

- 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 or Continuity of Care request will be granted.
- For behavioral health and substance abuse services, please contact your behavioral health and substance abuse carrier by calling the customer service phone number in your enrollment information or on your health care ID card.

Member Information

☐ New UnitedHealthcare member (Transition of Care applicant) ☐ Existing UnitedHealthcare member whose care provider terminated (Continuity of Care applicant)	Provider Termination Date

Name (Person being treated)	UnitedHealthcare Member ID Number	Date of Birth (mm/dd/yyyy)
Address	City	State/ZIP Code

Home/Cell Phone Number	Work Phone Number
Employer Name	Date of Enrollment in the UnitedHealthcare Plan (mm/dd/yyyy)

Member's Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent ☐ Other	Is the member 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 member named above. This information will be used to determine the member's eligibility for Transition of Care/Continuity of Care benefits under the plan.

Member's Signature/Parent or Guardian's Signature if Member is a Minor	Date (mm/dd/yyyy)

Care Provider Section: Your health care professional should complete the following information.		
Name (Treating physician or other health care professional)	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Facility Name, NPI/TIN, Address, City, 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 members: 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 applying for Transition of Care and Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care form for each condition. *attach additional clinical, as needed.

The above-named patient is a UnitedHealthcare member. We understand you are not, or soon will not be, a participating provider in the UnitedHealthcare network. The member has asked that for a defined period of time we extend coverage for care under the member's benefit plan for the covered services you provide as a non-participating provider. This is because of a qualifying condition. If we approve this request, you agree (1) to provide the covered service, including any follow-up care covered under the member's plan, and (2) if applicable, the terms and conditions of your participation agreement will continue to apply to the covered service, including any follow-up care covered under the member's plan. Please note the following:

- If applicable, payment under your participation agreement, together with any copayment, deductible or coinsurance for which the member is responsible under the plan is payment in full for the covered service and you will not seek to recover, and will not accept any payment from the member, UnitedHealthcare, or any payer or anyone acting on their behalf, in excess of payment in full, regardless of whether such amount is less than your billed or customary charge.
- Upon request, you will share information regarding the member's treatment with us.
- If applicable, you will make referrals for services including laboratory services, to network providers in accordance with the terms of your participation agreement.

Signature of Health Care Professional Date (mm/dd/yyyy)

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us, such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.