

Understanding Transition of Care and Continuity of Care.

Fully Insured California



Transition of Care

Transition of Care gives new Surest members 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 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 provider 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 apply for Transition of Care no later than 30 days after the date your Surest coverage begins, using the application beginning on page 5. Applications 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 4**.



Continuity of Care

Continuity of Care gives Surest members the option to request extended care from their current health care professional if they are no longer working with their health plan and are 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. Applications 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, or if you are a new Surest member, you must apply for Continuity of Care within 30 days of the health care professional's termination date using the form beginning on **page 5**.

How Transition of Care and Continuity of Care work:

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 of Care form below.

- A formal determination must be made by Surest 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 Continuity or Transition 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 Surest in consultation with your treating out-of-network health care professional 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 out-of-network care beyond the time frame approved by Surest, you must follow your plan's out-of-network requirements, including any prior authorization requirements.
- 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 conditions that may qualify for Transition of Care and Continuity of Care include, but are not limited to:

- 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 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.
- Newborn care for a child between birth and age thirty-six (36) months. Coverage under Transition of Care or Continuity of Care will not exceed twelve (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
- Recent major surgeries in the acute phase and follow-up period as long as the surgery has been recommended by the provider to take place within 180 calendar days of the provider's agreement termination date or 180 calendar days of your newly enrolled effective date
- 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.

- 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.
- 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 year. Completion of Covered Services will be provided for the duration of the illness.

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

- 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 Surest 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 apply 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, or you may not be eligible for the Transition of Care and Continuity of Care service. Applications received after 30 days will be reviewed on a case-by-case basis.
- Q** 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?
- A** 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 Transition of Care/Continuity of Care coverage for more than one medical condition, you should complete a Transition of Care/Continuity of Care Application for each specific condition.

Definitions

Transition of Care: Gives new Surest members 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 Surest members the option to request extended care from their current health care professional if they are no longer working with their health plan and are 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 all fully insured members residing 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 and Continuity of Care are 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. Applications 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 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 Surest plan to:
 - Surest
 - 600 Airborne Parkway
 - Cheektowaga, NY 14225
 - Attn: Transition of Care/Continuity of Care
 - Fax: 855-686-3561
- After receiving your request, Surest 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.

| Member Information | | | |
|---|---|--|-------------------|
| <input type="radio"/> New Surest member (Transition of Care applicant) <input type="radio"/> Existing Surest member whose care provider terminated (Continuity of Care applicant) | | Provider termination date | |
| Name (person being treated) | Surest member ID number | Date of birth (mm/dd/yyyy) | |
| Address | City | State/ZIP Code | |
| Home/cell phone number | | Work phone number | |
| Employer name | Employer policy number | Date of enrollment in the Surest plan (mm/dd/yyyy) | |
| Member's relationship to employee <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent <input type="radio"/> Other | Is the member currently covered by other health insurance carrier? <input type="radio"/> Yes <input type="radio"/> No If yes, carrier name: | | |
| Authorization to release records: I authorize all physicians and other health care professionals or facilities to provide Surest information concerning medical care, mental health, and/or substance use 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. | | | |
| For behavioral health, please check the applicable boxes. <input type="radio"/> ALL mental/behavioral health records | | If not ALL, please select one or more of the following record types: <input type="radio"/> Attendance <input type="radio"/> Discharge summary <input type="radio"/> Toxicology results <input type="radio"/> Assessments <input type="radio"/> Lab results <input type="radio"/> Treatment plan <input type="radio"/> Billing record <input type="radio"/> Medication/dosing <input type="radio"/> Other _____ <input type="radio"/> Consultations <input type="radio"/> Provider orders | |
| The following items require special consent by law. Check the boxes below to indicate your intent to include: <input type="radio"/> Alcohol or substance use information <input type="radio"/> HIV/AIDS <input type="radio"/> Genetic information <input type="radio"/> Reproductive health care services | | | |
| Please indicate in the space below the date(s) of service for the above selected records that you would like released. If this section is left blank, all dates of service for the above selected records will be included. _____ | | | |
| 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 |
| Provider license type (MD, NP, psychologist, LCSW, etc.) | | |
| 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: | | |
| <input type="radio"/> Life-threatening condition <input type="radio"/> Acute condition <input type="radio"/> Transplant <input type="radio"/> Inpatient/confined <input type="radio"/> Upcoming surgery <input type="radio"/> Disabled/disability <input type="radio"/> Terminal illness <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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. *attach additional clinical as needed. | | |
| <p>The above-named patient is a Surest 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:</p> <ul style="list-style-type: none"> • 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/Surest, 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) |

CONFIDENTIALITY NOTICE: Information in this document is considered to be Surest's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Any recipient shall be liable for using and protecting Surest's proprietary business information from further disclosure or misuse, consistent with recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement, or other applicable contract or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which may be a crime, and may also be subject to a civil penalty for each violation.

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.

Insurance coverage for fully insured plans is provided by All Savers Insurance Company (for FL, GA, OH, UT and VA), by UnitedHealthcare Insurance Company of IL (for IL), by UnitedHealthcare of Kentucky, Ltd. (for KY), or by UnitedHealthcare Insurance Company (for AL, AR, AZ, CO, DC, DE, GA, IA, ID, IN, KS, LA, MI, MN, MO, MS, MT, NC, NE, NH, NV, OK, PA, RI, SC, SD, TN, TX, UT, VA, WV and WY). These policies have exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company. Administrative services for insurance products underwritten by All Savers Insurance Company and UnitedHealthcare Insurance Company, and for self-funded plans, are provided by Bind Benefits, Inc. d/b/a Surest, its affiliate United HealthCare Services, Inc., or by Bind Benefits, Inc. d/b/a Surest Administrators Services, in CA.

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 benefisyè 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. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, नि:शुल्क 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 kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anida'awo'ígíí, t'áá jííik'eh, bee ná'ahóót'i'. T'áá shq'odí ninaaltsoos nítł'izí bee nééhozinígíí bine'deę' t'áá jííik'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.