Transition of Care

- Transition of Care gives new UMR members the option to request extended health coverage (medical and/or mental health/substance use) for specific health needs. New members can continue to see their health care professional at in-network rates, for a limited time due to a specific medical condition. The goal is to give you time until the safe transfer to an in-network healthcare professional can be arranged.
- You must apply for Transition of Care to be reviewed by UMR. You can apply 60 days ***prior to*** the effective date of your UMR plan and up to 30 days ***after*** the effective date of your UMR plan.
- If approved, your Transition of Care will be in effect for 90 days (for medical services and mental health/substance services) and 120 days (for ABA services) after the effective date of your UMR plan.

Continuity of Care

- Continuity of Care gives UMR members the option to request extended care from their current health care professional if the current health care professional is no longer working with their health plan after the effective date of your UMR plan and is now considered out-of-network.
- Members with medical reasons preventing an immediate transfer to an in-network health care professional may request extended coverage for services at in-network rates for specific medical conditions for 90 days from the date that their current health care professional is considered to be out-of-network.

How Transition of Care and Continuity of Care works:

You must already be under active and current treatment (see definition below) by the identified out-of-network 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 in-network level is available if the provider agrees to accept our in-network rates, provide medical records, follow our policies and a treatment plan approved by us.

- If your request is approved for the medical and/or mental health/substance use condition(s) listed in your form(s), you will receive the in-network level of coverage for treatment of the specific condition(s) by the health care professional for:
    - Up to 90 days from the effective date of coverage for new members (medical),
    - Up to 90 days from the effective date of coverage for new members (mental health/substance use) and up to 120 days for ABA services,
    - 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.
    - After this time, in-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 an in-network health care professional for you to receive in-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 include, but are not limited to:

Examples

Examples of medical conditions appropriate for the transition of care level of benefits include, but are not limited to:

- Women who are pregnant, this includes routine checkup through delivery and up to 6 weeks postpartum
- Patients undergoing treatment for cancer
- Organ transplant candidates awaiting a donor or under active treatment
- Inpatient at the time of the network change
- Any previous treatment for mental health/substance services
- Within three months post-acute injury or surgery
- An individual undergoing a course of treatment for a serious and complex condition that is either:
    - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.
    - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period.
- An individual undergoing Inpatient institutional care.
- An individual who is terminally ill and receiving treatment for such Illness by a provider or facility

Examples of medical 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.

Definitions:
Transition of Care: Gives new UMR members the option to request extended coverage from their current, out-of-network health care professional at in-network rates for a limited time due to a specific medical condition, until the safe transfer to an in-network health care professional can be arranged. **Continuity of Care:** Gives UMR members the option to request extended care from their current health care professional if the current health care professional 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 by a medical service within the last 30 days, but is evaluated on a case by case basis.

Transition of Care and Continuity of Care Form

This form is for self-funded members only.

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 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 within 60 days of the effective date and Continuity of Care within 30 days of the effective date of coverage or within 90 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 email the completed form along with relevant medical records and information to:

comcast_continuingcareform@umr.com

• After receiving your request, UMR will review and evaluate the information provided. Incomplete forms will be returned to the requestor. For COC forms UMR will send you a letter letting you know if your request was approved or denied, for the TOC form you will receive a phone call letting you know that the 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

☐ New UMR member (Transition of Care applicant) ☐ Existing UMR member whose care provider terminated (Continuity of Care applicant)		Provider Termination Date:
Name (person being treated):	UMR Member ID Number:	Date of Birth (mm/dd/yyyy):
Address:	City:	State/ZIP Code:

Home/Cell Phone Number:	Work Phone Number:
Employer Name and Group Number: **Comcast Cable Communications Management, LLC 76-416942**	Date of Enrollment in the UMR Plan (mm/dd/yyyy):
Member's relationship to Employee: ☐ Self ☐ Spouse ☐ Dependent ☐ Other	Is the member currently covered by another 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 UMR 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 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:

Please select the service description(s) that applies:
☐ Life-Threatening Condition ☐ Acute Condition ☐ Transplant ☐ Inpatient/Confined ☐ Upcoming Surgery
☐ Disabled/Disability ☐ Terminal Illness ☐ Mental Health/Substance Use ☐ 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 requesting Transition of Care and Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care form for each condition. ***attached additional clinical as needed***

We understand you are not, or soon will not be, as participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable time frame, (2) follow our policies and procedures, (3) upon request, share information regarding the member'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 member 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 member's plan. Payment under your participation agreement, along with any copayment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept and payment in excess of this amount from the member, 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 members: If the member is eligible, we will provide coverage at the network benefit level. Payment will be consistent with the member's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from us along with any copayment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept and payment in excess of this amount from the member, 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):