Continuity/Transition of Care FAQ

What is Continuity/Transition of Care?

It's a benefit that allows Anthem Blue Cross members to obtain ongoing care for those who are newly enrolling, when their treating doctors aren't in Anthem's provider network or when their provider is no longer part of our network. (Members with an Individual contract aren't eligible except when their prior health benefit plan withdraws from the market.)

How does it work?

Anthem helps eligible members (and their covered dependents) get ongoing care until their treatment is finished or until another network doctor takes it over. Time allowance is reviewed on case by case basis.

Who's eligible for transition of care/ continuity of care?

Members may be eligible if:

- Your primary medical group (PMG), independent physician association (IPA), preferred provider organization (PPO) provider, hospital or other provider leaves or is terminated from your health plan. That's called continuity of care.
- You're a newly covered member to Anthem Blue Cross and the doctor or other provider for that treatment was part of your previous plan, but is not part of your new Anthem Blue Cross plan. That's called transition of care.
- There are other reasons that you have no control over, which put the continuity of your care at risk. (So, members who change their coverage and go outside the network aren't eligible for the program.)

Who is not eligible?

- Members coming from an Individual contract except when their prior health benefit plan withdraws from the market.
- Members who choose to leave a plan that isn't changing and that still contracts with their provider (for example, a member who chooses to change plans or carriers at open enrollment when their employer is not making a change to their plan offerings).
- New enrollees being treated for non-acute or chronic clinical conditions usually aren't eligible for coverage of treatment by non-network providers. New enrollees with chronic conditions and who need help choosing a doctor for ongoing care, should contact our Member Services.
- Members where provider and/or facility has declined the reimbursement rate offered to cover services (member would be balanced billed for charges above max allowed amount under plan).

What kinds of treatment qualify for Continuity/ Transition of Care?

Some conditions that may be eligible for Continuity/ Transition of Care:

- An acute condition. A medical or behavioral health condition that involves a sudden onset of symptoms due to an illness or injury — or one that requires prompt medical attention (but for a limited time). You can likely complete the covered services for the duration of the acute condition.
- Serious chronic condition. A medical or behavioral health condition due to a disease, illness or other medical or behavioral health problem or disorder that is serious and continues without a cure, worsens over time or requires ongoing treatment to keep it in remission or from getting even worse. You can often complete covered services for a period of time for a course of treatment — and to arrange for a safe transfer to another provider, as we determine by consulting with you and your provider and consistent with good professional practice.
- Pregnancy. You can complete covered services for the three trimesters of your pregnancy and the immediate post-partum period.
- Terminal illness. An incurable or irreversible condition that has a high probability of causing death within one year or less. You can complete covered services, even if the duration of the terminal illness goes longer than 12 months from the contract termination date or from the effective date of coverage for a new enrollee.
- Care of a newborn child between birth and 36 months old. Completion of covered services may be considered for a limited period of time, not to exceed 12 months from the contract termination date or 12 months from the effective date of coverage.
- Surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled 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.

I just found out my employer is changing health plans and I have a scheduled surgery at a hospital that isn't in the Anthem network. What do I do?

You may be eligible for transition of care. Call Customer Service or fill out the *Continuity/Transition of Care Request Form Request Form* (see below).

What if I have a chronic condition?

If you need ongoing care for a chronic condition and you're not in an acute phase of your illness needing special treatment, you should select a provider from our network. If you do, you don't need to submit the *Continuity/Transition of Care Request Form Request Form*. If you need help choosing a new provider, please call Member Services.

How do I apply? Where do I get my form?

Prior to the first date of treatment or service that is planned after provider's termination date with Anthem, please call the Member Services (Toll number located on the back of your ID card) and they will assist you in completing a *Continuity/Transition of Care Request Form*. Or, if your employer provides you with a paper *Continuity/Transition of Care Request Form*, you can complete it and fax it to the number on the form.

Requests will be processed as soon as the new membership data is loaded into the Anthem Blue Cross system.

What happens after I've sent in my request?

For members, we confirm that we've received their request form by calling them. Our decision to approve or deny the request will happen no later than two business days from when we get all the information needed to make a decision.

How will I know if my request is approved?

When it's approved, we'll call you and send you a letter. Approval means that Anthem and your doctor have agreed to a transition care plan (and a reimbursement rate). You'll only have to pay for any participating deductible, coinsurance or copays that apply.

What if I need approval sooner than five days?

Urgent requests will be decided within two business days when we have all information received to make a decision. You will be notified of the decision by phone. Please note that delays can happen while attempting to work with your provider. If this occurs, we will notify you. To help expedite requests, notify your provider that you will be asking for a *Continuity/Transition of Care approval* from Anthem Blue Cross to continue care for a period of time.

What if the non-network provider doesn't accept Anthem's reimbursement rate for Continuity/Transition of Care and I still want to utilize that provider?

- If you're an HMO or EPO member, you'll have to pay for the full cost of treatment.
- If you're a PPO member, the provider would be considered out-of-network and you may have significant out-of-pocket costs.

What if I don't want to change my doctor, but I don't qualify for Continuity/Transition of Care?

You can still see the non-network doctor you have now, but you'll have higher copays and deductible. It may mean you have to pay the full cost of your doctor's services.

What if I have a Point-of-Service (POS) plan?

If your provider is in Anthem's provider network, you don't need Continuity/Transition of Care. (You have the option to go to a PPO contracted provider outside your HMO network under your POS benefit.) If your provider is not in Anthem's HMO or PPO network, you may be eligible for the benefit and should apply for it.

What if I have more questions?

For more information, please call the Customer Service number on the back of your ID card.