Health Plans
All Savers®
Alternate Funding

Transition of Care/Continuity of Care overview.

Transition of Care.

- Transition of Care gives new All Savers Alternate Funding members the option to ask for extended coverage from their current, out-of-network health care provider at network rates.
- This is for a specific medical condition and for a limited time until the safe transfer to a network provider can be arranged.
- You must apply for Transition of Care **no later than 30 days** after your All Savers Alternate Funding coverage begins.

Continuity of Care.

- Continuity of Care gives All Savers Alternate Funding members the option to ask for extended care from their current health care provider if he or she leaves the health plan network.
- Authorization may be requested when medical reasons prevent immediate transfer to a network provider.
- This is for a specific medical condition and for a limited time.
- You must apply for Continuity of Care **within 30 days** of your provider's termination date.

Health terms.

Having trouble understanding some of the health insurance terms on this form?

See definitions on page 3.

Apply for Transition or Continuity of Care using the application on pages 4-5.

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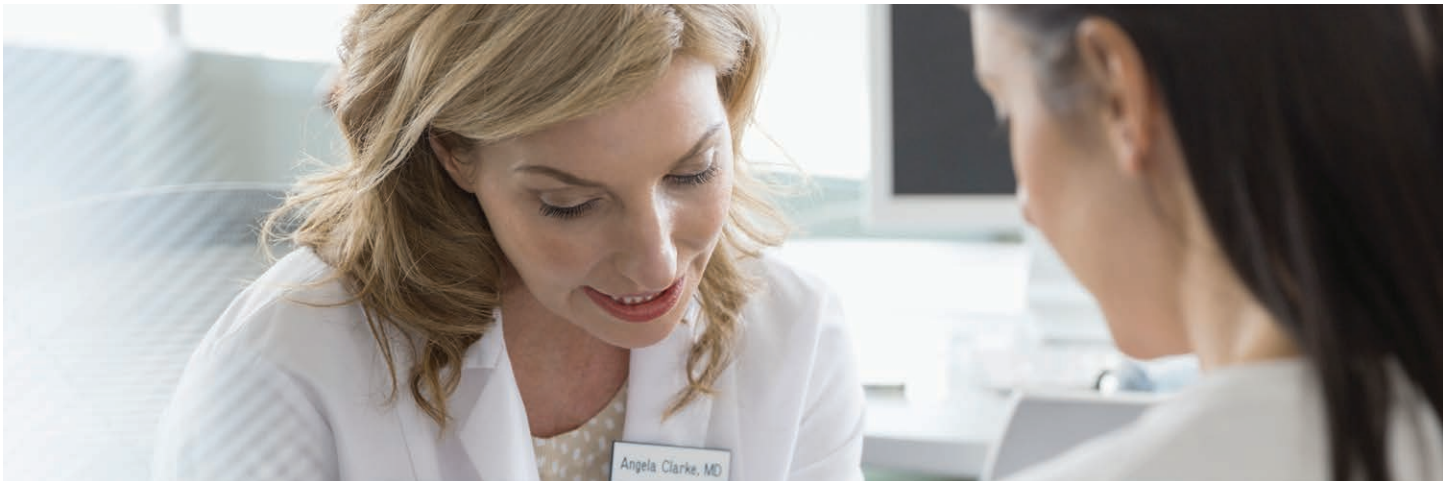

How Transition of Care/Continuity of Care works.

You must already be under active treatment by the non-network provider for the condition listed on the Transition of Care/Continuity of Care Application.

- Your request will be evaluated based on applicable state law and accreditation standards.
- If your request is approved by All Savers, you can receive the network level of coverage from the requested provider for treatment of the condition listed on your application for a specific time frame. All other services or supplies must be provided by a network provider for you to receive network coverage levels. If your plan includes out-of-network coverage, you must follow your plan's out-of-network requirements, including any prior authorization requirements, to continue receiving out-of-network care beyond the approved time frame.
- The availability of Transition of Care/Continuity of Care coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. For a service to be covered, a medical necessity determination and prior authorization may be required.

Examples of medical conditions that MAY qualify for Transition of Care/Continuity of Care:
• Pregnancy (trimester determined by state requirements) through 6 weeks postdelivery. - Transition of Care for the mother does not apply to the newborn. If the care provider or facility is out-of-network for the newborn, please submit a network gap request for services for the newborn by calling the number on your health plan ID card.
• 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 6 to 8 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/Continuity of Care:
• 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 (except as required by state law).

FAQs.

How soon do I have to apply for Transition of Care/Continuity of Care?

You must apply within 30 days of your effective date of coverage. If your provider leaves the network, you must apply within 30 days of the provider's termination date.

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

Authorization is in effect for a specified period or until care has been completed or safely transitioned to a network provider, whichever comes first.

If I am approved for Transition of Care/Continuity of Care for one medical condition, can I receive network coverage from a non-network provider for an unrelated condition?

No. Transition of Care/Continuity of Care coverage is for the specific medical condition only and cannot be applied to another condition. If you are seeking 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 All Savers Alternate Funding 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 (see examples on page 2), until the safe transfer to a network provider can be arranged.
- **Continuity of Care:** Gives All Savers Alternate Funding 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.
- **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.
- **Preauthorization:** 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 provider visits to monitor an illness or disorder, provide treatment, prescribe medication or treatment, or modify a treatment plan. Discontinuing active treatment could cause a recurrence or worsening of the condition and interfere with recovery. Generally, an active treatment is defined as within the last 30 days. This is evaluated on a case-by-case basis.

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

Transition of Care/ Continuity of Care Application

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This form is for all self-funded members.

Important information:

- Please make sure all fields are completed.
- When the application is complete, it must be signed by the member for whom the Transition of Care/Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.
- You must apply for Transition of Care/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/Continuity of Care Application must be completed for each condition for which you and/or your dependents are seeking Transition of Care/Continuity of Care.**
- Mail or fax the completed application along with relevant medical records and information to:

  All Savers
  P.O. Box 31375
  Salt Lake City, UT 84131-0375
  Fax: 1-844-440-7570

- All Savers will review and evaluate the information provided. Incomplete forms will be returned. 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 application does not guarantee that a Transition of Care/Continuity of Care request will be approved.
- For behavioral health services, contact your behavioral health carrier by calling the Customer Service phone number on your health plan ID card.

Member information

☐ New All Savers member (Transition of Care applicant) ☐ Existing All Savers member whose care provider left the network (continuity of care applicant)		Provider Termination Date
Name (Person being treated)	All Savers 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 All Savers 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 All Savers 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

Care provider section: Your health care professional should complete the following information

Name	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Hospital		Hospital 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 **one** of the descriptions if it applies:

☐ Life-Threatening Condition ☐ Acute Condition ☐ Transplant ☐ Inpatient/Confined
☐ Upcoming Surgery ☐ Disabled/Disability ☐ Terminal Illness ☐ Ongoing Treatment

Newborn Members: Transition of Care for the mother does not apply to the newborn. If the health care professional or facility is out of network for the newborn, please submit a network gap request for services for the newborn by calling the number on the member ID card.

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

Current and Associated Treatment(s)/Comments (include all relevant CPT codes): If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care coverage, please complete a separate Transition of Care/Continuity of Care Application for each condition.

The above-named patient is an All Savers 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 treat claims as network 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, All Savers, 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)

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