Transition-of-care coverage questions and answers

Q. What is transition-of-care (TOC) coverage?
A. TOC coverage is temporary. You can get TOC when you become a new member of a medical benefits plan or change your plan, and you are being treated by a doctor who:
   • Is not in the plan’s network
   • Is not included in Aexcel, tier 1 (for tiered network plans) or plan sponsor specific networks, and your benefits change to include one of these networks

TOC coverage can also apply when your doctor leaves the plan’s network or changes network status or if certain laws or regulations require coverage. Approved TOC coverage allows a member who is receiving treatment to continue the treatment for a limited time at the highest plan benefits level.

TOC coverage is only for the requested doctor. Except in New York, TOC coverage does not include health care facilities, durable medical equipment (DME) vendors or pharmaceutical items. If we approve TOC coverage, the doctor must use a health care facility, DME vendor or pharmacy vendor in the plan’s network. If you want to request coverage for a vendor or facility outside the plan’s network, call the Member Services phone number on your ID card.

Q. What is an active course of treatment?
A. An active course of treatment means you have begun a program of planned services with your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some active course-of-treatment examples may include, but are not limited to members who:
   • Enroll with the plan after 20 weeks of pregnancy, unless there are specific state or plan requirements (Members less than 20 weeks pregnant whom the health plan confirms as high risk are reviewed on a case-by-case basis.)
   • Have completed 14 weeks of pregnancy or more and are receiving care from a plan’s participating practitioner whose network status changes.
   • Are in an ongoing treatment plan, such as chemotherapy or radiation therapy.
   • Have a terminal illness and are expected to live six months or less.
   • Need more than one surgery, such as cleft palate repair.
   • Have recently had surgery.
   • Are being treated for a mental illness or for substance abuse. (The member must have had at least one treatment session within 30 days before the status of the member or the participating health care provider changed.)
   • Have an ongoing or disabling condition that suddenly gets worse.
   • May need or have had an organ or bone marrow transplant.

To be considered for TOC coverage, treatment must have started before the enrollment or re-enrollment date, or before the date your doctor left the health plan’s network, or before the date a doctor’s network status changed.

Q. What other types of providers, besides doctors, can be considered for TOC coverage?
A. This includes health care professionals such as physical therapists, occupational therapists, speech therapists and agencies that provide skilled home care services, such as visiting nurses. TOC is considered for participating hospitals only when the facility is not designated for the highest benefit level for plans that include tiered networks. TOC does not apply to other health care facilities (for example, skilled nursing facility), DME vendors or pharmaceutical items.

Q. If I am currently receiving treatment from my doctor, why wouldn’t you approve my request for TOC coverage?
A. If you’re receiving treatment, the procedure or service must be a covered benefit. Your doctor must also agree to accept the terms outlined on the TOC request form.

Q. My PCP is no longer a participating provider. If my plan requires me to select a PCP, can I still see my doctor?
A. If you’re receiving treatment, you may still be able to visit your PCP, even if he/she leaves the network. In all states, except Texas and New Jersey, you may need to select a PCP in the health plan’s network. In Texas and New Jersey, TOC may apply to PCPs. Talk to your PCP so that he/she can help you with your future health care needs.

Q. How long does TOC coverage last?
A. Usually, TOC coverage lasts 90 days, but this may vary based on your condition (for example, pregnancy). We will tell you if your TOC coverage request is approved and how long the coverage will last.

Q. How do I sign up for TOC coverage?
A. Contact the Member Services number on your member ID card. You must submit a TOC request form to the health plan:
   • Within 90 days of when you enroll or re-enroll
   • Within 90 days of the date the health care provider left the plan’s network
   • Within 90 days of a doctor’s network status change

You or your doctor can send in the request form.

Q. How will I know if my request for TOC coverage is approved?
A. We will send you a letter via U.S. mail. The letter will say whether or not you are approved.

Q. Does TOC coverage apply if my plan does not have a provider network?
A. No.

Q. What if I have an Aexcel or plan sponsor specific network plan?
A. If we approve your TOC coverage, you may still receive care at the highest benefits level for a certain time period. If you continue treatment with this doctor after the approved time period, your coverage would be limited to what your plan allows. This means you may have reduced benefits or no benefits.

Q. What if I have more questions about TOC coverage?
A. Call the Member Services phone number on your ID card. If you have questions about TOC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health or behavioral health number.