Transition of care explained

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 health care professional can be arranged.

How transition of care works:

- You must apply for transition of care to be reviewed by UMR. Please refer to the Summary Plan Description (SPD) to determine the application time frame.
- If approved, your transition of care will be in effect for the time frame indicated in the SPD.
- You must already be under active and current treatment (see definitions section) by the identified out-of-network health care professional for the condition identified on the transition of care form.
- 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 the time frame indicated in the SPD.
- 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 your health plan ID card for assistance.
- The availability of transition 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.

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Qualifying transition of care medical conditions

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

- Women who are pregnant.
- 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.

Medical conditions that do not qualify for transition of care

Examples of medical conditions that do not qualify for transition 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.

Network (in-network): The facilities, providers and suppliers your health plan has contracted with to provide health care services.

Out-of-network (non-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.

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