# Special Notice Regarding
# Continuity and/or Transition of Care

Your Member Handbook is amended by the following changes.

In the Continuity and/or Transition of Care section under Eligibility and Enrollment the information is deleted and is replaced with the following:

### Continuity and/or Transition of Care

If we authorize you for care through an out-of-network provider while we are transferring your care to an in-network provider, we will pay at least usual and customary amounts for your services. You pay your in-network cost-share.

Examples of conditions that may require continuity or transition of care:

- Behavioral health conditions during active treatment
- Currently hospitalized
- Currently taking drugs for which we require UM review
- Currently on a transplant list
- Impending hospitalization
- Currently pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
- Terminal illness
- Undergoing chemotherapy or radiation therapy

The approved out-of-network care ends when:

- You transfer to a network provider;
- You reach benefit limitations; or
- Care is excessive or not medically necessary.

The approval applies only to the condition and the provider shown in the approval letter. An in-network provider must treat all other conditions. If you need referral services, we may authorize for in-network providers only.

Others that may help with this process include.

- Your doctor or pharmacist.
- The parent of a child under 18 years of age.
- Your power of attorney with medical decision authority. We must have a copy of the signed power of attorney form on file.
- Your authorized representative. See “Appointment of Authorized Representative” on page 145. You will need to complete the form if you want us to share your PHI with anyone else, for example:
    - Your parent, if you are age 18 or over.

- Your spouse.
- Your caregiver, friend, neighbor, or other.

If we do not approve ongoing care through the out-of-network provider, you may appeal the decision. See "Appeals and Grievances" on page 139.

**Behavioral Health and Medical Transition of Care**
If you are enrolling in GlobalHealth and changing from another health insurance company, you may be eligible for care with your present provider while we are transferring your care to an in-network provider.

You will need to complete the *GlobalHealth Transition of Care Request Form*. This is necessary, even if your PCP is also a GlobalHealth provider. Some specialists and facilities currently scheduled for your care may differ from our network. You can find the form on our website.

You must get approval from us to continue care with your current provider. Approval from your prior health insurance company is not the same as authorization from us.

Requests for ongoing medical care are reviewed case-by-case. Once we have the request, we will review your case. You must have received services from the requested provider under an ongoing course of treatment in the 90 days prior to your effective date with us to be considered.

We will tell you and your provider if we are going to:
- Authorize continued services; or
- Move your care to one of our network providers right away. We will tell you about your right to appeal the decision.

If approved for transition care, we cover care until the earlier of 90 days or the date on which you are no longer a continuing care patient with respect to such provider or facility. If you are pregnant, we cover transition care through six weeks postpartum, even if it is more than 90 days. If you remain enrolled in the same plan across calendar years, these timeframes apply across calendar years.

**Prescription Drug Transition of Care**
If you are new to GlobalHealth, you may ask us to:
- Cover non-formulary drugs; or
- Waive restrictions on Formulary drugs.

You must make the request within the first 90 days of your effective date of coverage. We urge you to work with your doctor and the Pharmacy Department as soon as possible to move to our *Drug Formulary*.
1. Complete the *GlobalHealth Transition of Care Request Form - Prescriptions* from our website.
2. We will verify previous drug therapy.

3. We will tell you our decision, whether or not it is in your favor. If approved, you will get one 30-day prescription fill per drug. If not approved, you may ask for an external review.

For more information, see "Exception Requests" on page **Error! Bookmark not defined.**.

**Behavioral Health and Medical Continuity of Care**

If you are a current GlobalHealth member and your provider leaves the network, you may keep getting care from that provider in certain cases while we are transferring your care to an in-network provider.

You must be in active treatment. "Active treatment" means:

- Ongoing treatment for a serious and complex condition from the provider or facility;
    - in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
    - in the case of a chronic illness or condition, a condition that is:
        - life-threatening, degenerative, potentially disabling, or congenital; and
        - Requires specialized medical care over a prolonged period of time.
- Ongoing a course of institutional or inpatient care from the provider or facility;
- Ongoing course of treatment for a pregnancy from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Ongoing treatment for an individual determined to be terminally ill and is receiving treatment for such illness from such provider or facility; or
- Ongoing treatment for which a treating doctor or other Provider attests that changing care to another doctor or Provider would make the condition or expected outcome worse.

If approved for continuity care, we cover care for up to 90 days while we are working to transfer your care. If you are pregnant, we cover continuity care through six weeks postpartum, even if it is more than 90 days. If you remain enrolled in the same plan across calendar years, these timeframes apply across calendar years.

You must get approval from us to continue care. We will not cover continuing care when:

- The provider's contract ended due to quality of care issues.
- The provider did not comply with quality standards or for fraud.

Except as amended, your Handbook remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR MEMBER HANDBOOK FOR FUTURE REFERENCE.