Transition of Care
Questions and Answers

Q: What is Transition of Care?
A: Transition of Care (TOC) allows for minimal disruption of care and permits a member to continue care for a transitional period of time after the PPO change date, without penalty, at the preferred (in-network) level of benefits when his/her Cigna PPO healthcare provider is not in the current First Health PPO network.

Q: What providers can be approved for TOC?
A: TOC coverage applies to the following types of providers: Individual practitioners, medical groups, independent practice associations, acute care hospitals, or state licensed institutions to deliver or furnish health care services. Examples of individual practitioners include doctors, psychiatrists, licensed therapists and qualified autism service providers, professionals, physical therapists, occupational therapists, speech therapists, and agencies that provide skilled home care services such as visiting nurses. Providers considered for transition coverage may vary by condition, as described above. TOC does not apply to durable medical equipment (DME) vendors or pharmaceutical items.

Q: When is TOC considered for approval?
A: TOC coverage is considered for an active course of treatment, meaning that the patient began a program of planned services with their doctor to correct or treat a diagnosed condition. Service may be eligible for TOC only if the first date of service or treatment was incurred prior to the PPO network change to First Health. TOC does not apply to patients newly insured on or after the PPO change date, or to care provided by a provider that did not participate in the Cigna PPO network. An active course of treatment covers a certain number of services or period of treatment for special situations.

Q: What conditions are eligible for TOC?
A: TOC coverage is provided under certain circumstances for the completion of covered services for the following examples of conditions, including but not limited to:

- Insured who has completed 14 weeks of pregnancy or greater and are receiving care from a participating PPO provider under the Cigna PPO network. TOC also applies to the immediate postpartum period.
- An acute condition that involves the sudden onset of symptoms due to an illness, injury, serious mental illness or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services will be provided for the duration of the acute condition.
- Previously scheduled surgery or other procedure as part of a documented course of treatment. The documentation must show that the provider recommends procedure occur within 60 days of the PPO network change.
- A terminal illness that is an incurable or irreversible condition and has a high probability of causing death within one year or less.
- A serious chronic medical condition or mental illness due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services will be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan, in consultation with the member, the nonparticipating provider, and consistent with good professional practice.
- Insured in an ongoing treatment plan, such as chemotherapy or radiation therapy.
- Insured who needs more than one surgery, for a condition, such as cleft palate repair.
- Insured who recently had surgery.
• Insured who has received outpatient treatment for a mental illness or for substance abuse. (The insured must have had at least one treatment session within 30 days prior to the PPO network change date.)
• Insured who is currently on an active organ transplant list or has had an organ or bone marrow transplant.

**Q: If I am currently receiving treatment from my doctor, why wouldn’t my request for TOC coverage be approved?**
**A:** In addition to currently receiving treatment, your request must involve a covered procedure/service.

**Q: How do I apply for TOC coverage?**
**A:** Visit Student Health Services to update your referral and complete this TOC Request Form.
[**FAX to PIA at 1-818-735-3567** or mail it to:]
Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040

**Q: How will I know my request for TOC has been approved?**
**A:** You will receive a letter by U.S. Mail to the address provided on the TOC Request Form. The letter will state whether or not the request is approved. If TOC coverage is approved, you may continue treatment with the out-of-network providers for the approved period of time.

**Q: What if I continue treatment with an out-of-network provider if the TOC request is not approved?**
**A:** If TOC coverage is not approved, your coverage would follow what is stated in your plan design for out-of-network providers. This means you may have reduced benefits or no benefits.

**Q: What if I have questions about completing the TOC Request Form?**
**A:** Call Personal Insurance Administrators, Inc. (PIA) at 1-855-515-2423 Monday – Friday from 8:00 a.m. to 5:00 p.m. (4:00 p.m. on Friday) PT. This is the same customer service number on your new ID card.
Transition of Care
Request Form

For Medical Care and/or Behavioral Health Care: Only complete this form if you are receiving ongoing care or are scheduled for care. If your provider is a member of the Cigna PPO network and is not in the current First Health PPO network after the PPO change date, complete the entire form below. FAX to PIA at 1-818-735-3567.

If your provider is a member of the current First Health PPO network after the PPO change date, you do not need to complete this form.

Fill out the form completely and do not leave any blanks. Use N/A if the information requested does not apply. Complete a separate form for each family member who needs to request Transition of Care.

Student Name: ____________________________ Student ID Number: ____________________________
Patient Name: ______________________________ Relationship to Student: ______________________
Mailing Address: ________________________________________________________________
Student Date of Birth: ____________________________ Patient Date of Birth: ____________________________
Student Campus: ________________________________________________________________

Do you have ongoing care as described above (and in the Q&A section) with a provider in the Cigna PPO network that is not in the current First Health PPO network after the PPO change date? Yes  No

If yes, you MUST provide the information below for all providers to be considered for TOC (including doctors, hospitals, and other providers):

<table>
<thead>
<tr>
<th>PROVIDER TYPE* (Example)</th>
<th>PROVIDER OR FACILITY NAME*</th>
<th>FULL ADDRESS CITY, STATE, ZIP*</th>
<th>PHONE NUMBER*</th>
<th>DATE OF NEXT VISIT*</th>
<th>DIAGNOSIS OR CONDITION*</th>
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<tbody>
<tr>
<td>Behavioral Health</td>
<td>John Smith, MD</td>
<td>123 Main Street Irvine, CA 92601</td>
<td>(714) 123-4567</td>
<td>10/01/2013</td>
<td>Anxiety</td>
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* This information is required. Do not leave blank.

Diagnosis or condition (include pertinent history and a detailed explanation):
______________________________________________________________________________
______________________________________________________________________________

Do you have any hospitalizations, surgeries or procedures scheduled? Yes  No

I hereby authorize the providers listed to give any information and medical records to PIA necessary to make a decision regarding my request for Transition of Care. I understand that I am entitled to a copy of this authorization form. I also authorize PIA to leave confidential information on my voice mail at the following numbers (check all that apply):

__ Home: (   ) ______________  __ Work: (   ) ______________  __ Cell: (   ) ______________
__ DO NOT leave confidential information on my voice mail

Signature of Patient (if 18 or over): ________________________________________________

Signature of Parent or Guardian (if under 18): ______________________________________