

Transitional Care Policy

To make a request for Transitional Care, you or your physician must contact the Blue Cross Blue Shield Customer Service area at the phone number located on the back of your identification (ID) card. When making the request, you must provide:

- (1) The name, specialty, address, and telephone number of the out-of-network provider.
- (2) The service or condition for which the request is being made.
- (3) The time period to be considered.

Once your request is processed and approved, you will be sent a notification letter. The letter will include:

- (1) The date on which transition of care will begin.
- (2) The date on which transition of care will end.
- (3) Instructions on how to identify a network physician before the designated end date.

This letter will be sent within one working day of the date on which the request for transition of care was approved.

If a transition of care request is denied, written notice of the denial will be sent to you within one business day of the decision. You will be advised of your right to appeal the decision. Appeals will be governed by the procedures and timeframes contained in the notice you receive at that time.

Transitional Care Benefits: Services and Conditions

Service/Condition	Guideline
Neonatal Care	Services that occurred prior to or during the first 45 days of the effective date of coverage will continue to be paid to the out-of-network physician through the patient's discharge date and one follow-up visit. Additionally, if the physician approved on the transition of care request refers services to an out-of-network provider, no enrollee co-payments will be imposed.
Neonatal Intensive Care	Such services will continue to be paid to the out-of-network physician for the entire admission, usual post hospital care and follow-up visits. Additionally, if the physician approved the transition of care request refers services to an out-of-network provider; no enrollee co-payments will be imposed.
Pregnancy	An enrollee who is in the second trimester of pregnancy at the time coverage becomes effective, may remain with the out-of-network OB/GYN physician until six (6) weeks after delivery with no enrollee co-payments for physician services only. Additionally, if the out-of-network physician approved to provide transition of care refers the patient to other non-network professional providers for covered services, no enrollee co-payments will be imposed. Other services, not related to the pregnancy, are subject to out-of-network guidelines.
Terminal Care	Services provided to enrollees who are terminally ill will continue to be paid to the out-of-network physician for a period of six months.

Chemotherapy and Radiation Therapy	Therapies that begin prior to or during the first 45 days of the effective date of coverage may be considered for in-network benefits for the duration of that episode of chemotherapy or radiation therapy.
Inpatient Care	Services provided during an inpatient stay that began prior to or during the first 45 days of the effective date of coverage will continue to be paid to the out-of-network physician. If the provider performed surgery during the inpatient stay, he/she will be paid for that surgery, postoperative care and one follow-up visit.

Frequently Asked Questions

How do I determine if my doctor/hospital is in the BCBS National PPO network?

Call the national toll-free number at 1-800-810-2583 or search the BCBS website at <http://www.bcbs.com/healthtravel/finder.html>.

If my doctor is not in the BCBS National PPO network, can he or she join the network?

Your provider may contact the Provider Inquiry Department at the local BCBS Plan to determine how to apply for participation.

What happens if my in-network doctor refers me to a physician who is not in the network?

If your in-network provider refers you to an out-of-network provider and the referral is approved, the in-network rules apply. Services received out-of-network without an approved referral, are subject to the 10% co-insurance and you will be responsible for any charges above the BCBS maximum allowable payment amount.

I am in the middle of a course of treatment with an out-of-network doctor. What should I do?

Enrollees must contact the local BCBS plan to request the transitional care benefit. A Transitional Care Policy allows members to continue to receive care from an out-of-network provider for specific conditions and usually for a limited time period. While receiving transitional care, the member should take steps to transfer his/her care to a provider who participates in the network. The conditions and time periods are:

- Pregnancy if the member is in the 2nd or 3rd trimester – up to 6 weeks after the date of the child's birth.
- Maternity hospital admission – through the date of discharge from the hospital and one follow-up visit.
- Premature birth resulting in admission to the neonatal intensive care unit – for the infant's entire stay in the neonatal intensive care unit and through follow-up care.
- Kidney disease involving dialysis – up to three months.
- Cancer involving chemotherapy or radiation treatment – up to three months.
- Terminal illness – up to six months.

If you are hospitalized – covered through the date of discharge and one follow-up visit.

I am a Medicare enrollee. How does the BCBS National PPO Plan impact me?

Enrollees who have Medicare are included in this new healthcare plan and will also receive new ID cards prior to the effective date. However, covered services that are Medicare primary claims are not subject to the 10% co-insurance for out-of-network services.