MediExcel Health Plan Continuity of Care Benefits

Continuity of Care benefits are intended to provide coverage for individuals who meet all the following criteria:

1. They have one of several specified medical conditions.
2. They require ongoing treatment for a certain period of time.
3. They are receiving services from doctors, other health care professionals, hospitals or other facilities whose contractual relationship with MediExcel Health Plan is terminating or is not currently contracted by MediExcel Health Plan.

If an individual meets all the criteria, MediExcel Health Plan will contact the terminated / non-contracted health care professional and attempt to arrange for the provision of covered services. If the health care professional does not agree to MediExcel Health Plan's contractual terms and conditions, MediExcel Health Plan may deny or only provide limited Continuity of Care benefits.

How it Works:

- To request Continuity of Care, you must submit a completed Continuity of Care Request Form within 30 days of your health care professional's or your coverage termination date.
- You must already be receiving care for a qualifying medical condition by the terminated health care professional identified on the Continuity of Care Request Form.
- If Continuity of Care benefits are approved; you will receive the in-network level of benefits for treatment of the specific condition for either a specified timeframe or the duration of the condition.
- Approved benefits only apply to the treatment provided or ordered by the doctor identified on the Continuity of Care Request Form for the medical condition specified on the form.
- The availability of Continuity of Care benefits does not mean a treatment is covered, nor does it constitute pre-authorization of medical services to be provided. Benefit determinations and pre-authorizations must still be obtained during the pre-certification and case management process.
- You will be responsible for the cost of any services rendered by any terminated health care professional unless they are approved by MediExcel Health Plan for Continuity of Care benefits.

Medical conditions and other situations that may qualify for Continuity of Care benefits include:

- An **acute condition**, for the length of the acute condition. An "acute condition" is defined as a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.
- A **serious chronic condition**, for a period needed to complete a course of treatment and to arrange for a safe transfer to another doctor, as determined by MediExcel Health Plan in consultation with the enrollee and treating health care professional, consistent with good professional practice. This period shall not exceed 12 months from the health care professional's contract termination date. A "serious chronic condition" is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and:
    - persists without full cure;
    - worsens over an extended period of time; or
    - requires ongoing treatment to maintain remission or prevent deterioration.
- A **pregnancy**, for the length of the pregnancy (*three trimesters*) and the immediate postpartum period.
- A **terminal illness**, for the length of the terminal illness. A "terminal illness" is an incurable or irreversible condition that has a high probability of causing death within one year or less.
- **Care of a newborn child whose age is between birth and age 36 months**, regardless of whether the child is undergoing an active course of treatment, for a period not to exceed 12 months.
- **Performance of surgery or other procedure that has been authorized by the plan**, as part of a documented course of treatment that is to occur within 180 days of the doctor's contract termination date.

If I am approved for Continuity of Care benefits for one illness, can I receive in-network benefit payments for a non-related condition?

In-network benefit levels provided as part of Continuity of Care benefits are for the specific illness/condition only and cannot be applied to another illness/condition. You must complete a Continuity of Care Request Form for each unrelated illness/condition no later than 30 days after the health care professional's termination date.

MediExcel Health Plan Continuity of Care Request Form

*****ATTENTION: You may not need to complete this form*****

- Complete this form only if you are utilizing a non-participating health care professional. Please check the MediExcel Health Plan website (**www.mediexcel.com**) to confirm that your doctor is in the MediExcel Health Plan provider network.
- See reverse for instructions to complete this Continuity of Care Request Form.
- **Use a separate form for each condition**. Photocopies are acceptable. Attach additional information if necessary.

Employer:	Policy #:	Employee Date of Enrollment in MediExcel Health Plan (mm/dd/yyyy)
Employee Name:		Telephone Number:
Street Address: City: State: Zip:		
Patient's Name:	Patient's Birthdate (mm/dd/yyyy)	Relationship to Employee ☐ Spouse ☐ Dependent ☐ Self

1. Is the patient pregnant? ☐ Yes ☐ No If so, when is the due date? _____ (mm/dd/yyyy)

2. Is the patient receiving treatment for an acute condition or trauma? ☐ Yes ☐No

3. Is the patient scheduled for surgery or hospitalization after their effective date with MediExcel Health Plan? ☐ Yes ☐No

4. Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or a candidate for Organ Transplant? ☐ Yes ☐No

5. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☐No

6. Is the patient receiving mental health/substance abuse care? ☐ Yes ☐No

7. Is the patient receiving care for a terminal illness? ☐ Yes ☐No

8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Continuity of Care in section **8.a**.

9. Please complete the provider information below.

Doctor's Name:		Telephone # of Provider:	
Doctor's Specialty:			
Doctor's Address:	City:	State:	Zip:
Hospital Where Patient's Doctor Practices:		Telephone # of Hospital:	
Reason/Diagnosis:			
Date(s) of Admission (mm/dd/yyyy):	Date of Surgery (mm/dd/yyyy):	Type of Surgery:	
Treatment Being Received and Expected Duration:			

10. Is this patient expected to be in the hospital when or after coverage with MediExcel Health Plan begins? ☐ Yes ☐No

11. Please list any other continuing care needs that may qualify for Continuity of Care benefits in section **11.a**

I hereby authorize the above physician to provide MediExcel Health Plan with any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care Benefits under MediExcel Health Plan. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian:	Date (mm/dd/yyyy)

Instructions for Completing the Continuity of Care Request Form

- You must complete a separate Continuity of Care Request Form for each condition for which you or your dependents seek Continuity of Care benefits. Additional forms are available through the MediExcel Health Plan website at **www.mediexcel.com**. You may use photocopies.
- Please answer all questions completely.
- Completed forms should be signed by the patient for whom Continuity of Care benefits have been requested. If the patient is a minor, a guardian must sign the form.
- You must apply for Continuity of Care benefits within 30 days from your health care professional's or your coverage termination date. Completed forms should be marked "Confidential" and forwarded to the address below.

Important Notes

Please Mail or Fax form to:

MediExcel Health Plan
750 Medical Center Court, Suite 2
Chula Vista, CA 91911
Fax: (978) 522-3777

8.a: Please include information about your current or proposed treatment plan and how long your treatment is expected to continue. If surgery has been planned, state the type and the proposed date of your surgery. Use an additional sheet if necessary.

11.a: Briefly state the health condition. When did it begin and what doctor is currently involved? How often do you see this doctor? Be as specific as possible. Use an additional sheet if necessary.