Planned Administrators, Inc. (PAI)
Continuation of Care (CoC) Request Form

Purpose of Transition of Care and Continuation of Care

If circumstances change and a member's provider is not in-network or no longer in-network, PAI strives to make the transition seamless. A member with these circumstances can make a special request to have benefits with his or her original provider paid at the in-network level for a limited amount of time.

Continuation of Care for Serious Medical Condition allows benefits for members to continue care with a network provider that is leaving the network. Continuation of care requires approval from medical management. If approved, members are allowed network level benefits for a limited amount of time.

Examples of medical or behavioral health conditions that may meet Continuation of Care guidelines:

- A member who is undergoing a course of treatment for a serious and complex medical or behavioral health condition from a provider or facility
- A member who is currently undergoing a course of institutional or inpatient care from a provider or facility
- A member who is scheduled to undergo non-elective surgery from the provider
- A member who is pregnant and undergoing a course of treatment for the pregnancy from a provider or facility
- A member who is determined to be terminally ill and has a life expectancy of 6 months or less

Serious and Complex Condition:

- A member with an acute illness that is serious enough to require specialized medical or behavioral health treatment to avoid the reasonable possibility of death or permanent harm
- A member with a chronic illness or condition that is life threatening, degenerative, potentially disabling or congenital
- A member that requires specialized medical or behavioral health care over a prolonged period of time

Continuation of Care may be available for a limited time or until the member is no longer a Continuation of Care patient for a period of ninety (90) days, whichever is the shorter time.

Examples of medical or behavioral health that may not meet Continuation of Care guidelines, depending on the circumstances:

- Routine examinations, vaccinations, testing or health assessments
- Stable chronic conditions (e.g., diabetes, allergies, arthritis, asthma, hypertension, depression, anxiety, bipolar disorders, etc.)
- Minor illnesses (e.g., colds, sore throats, ear infections, bronchitis, strains, sprains, etc.)
- Elective surgery or surgery scheduled at a time for your convenience
- Long-term management of cancer, renal failure, dialysis, transplants, etc.

Continuation of Care Benefit Enrollment Process

Send your request for CoC in writing via fax to (803) 462-6842, by email: PAI_General.appeals_Fax@paisc.com.
You can also mail it to:

Planned Administrators, Incorporated
P.O. Box 6927
Columbia, South Carolina 29260
Attn: Medical Review Staff, Request for Continuation of Care

Upon receipt of the request form, our Medical Review Staff, we will review and evaluate the information. Based upon this initial information, we will inform the member in writing of the decision regarding your request for continuation of care in one of three ways:

1. Request approved; or
2. Request denied; or
3. Request for additional information. Additional information is needed in order to make a final determination.

Although we do our best to expedite the process, the review process takes an average of 10 business days to complete. As part of the review process, whether the request will be approved or denied, PAI's Medical Review Staff will work with the member to identify alternatives for in-network providers, and facilitate the transition of the member's care to in-network providers and facilities.

After an approved continuation of care period has expired, we will reimburse covered services at the out-of-network benefit level.

Planned Administrators, Inc. Continuation of Care Request Form

(Please use a separate form for each condition)

Patient's Name DOB ID#

Address City/State/ZIP

Effective Date

Phone: (Home) _____ (Work) _____

Relationship to Member/Subscriber: [ ] Self [ ] Spouse [ ] Dependent

Health Condition: _____

Physician/Provider(s) Involved

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Date of First Treatment: _____ Date of Last Visit: _____

Current Treatment or Proposed Surgery: _____

Expected Length of Treatment or Date of Surgery: _____

Primary Care Physician

Provider's Name Member Health Plan ID #

Address

City/State/ZIP

AUTHORIZATION TO RELEASE INFORMATION

I authorize _____
Non-Participating Specialist's Name

_____
Address and Phone Number

To release to Planned Administrators, Inc. (PAI) all information relating to past, present and future health care examinations, conditions and treatments for:

_____
Brief Description of Medical Condition

_____

I hereby authorize PAI's Medical Review Staff to get any information and medical records necessary from the above physician(s) to make an informed decision concerning my request for treatment in progress benefits under my medical plan. This authorization will expire six months from the date signed below. I understand I am entitled to a copy of this authorization form.

I understand that I may be balance billed by the provider for the difference between the allowed amount and the providers' charges. I am also responsible for the member liability for deductibles, coinsurance and copayments. I understand that if the Plan pays all benefits to me, I will be responsible for paying any amount owed to the provider.

Patient's Name: _____ Health Plan ID #: _____

Patient's Signature: _____ Date: _____

Employee's/Legal Guardian's Signature*: _____ Date: _____

*If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.

For Internal Use Only:

_____ _____
Employee's Name Employee ID #

Notes:

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)