

LOCAL 99 Health & Welfare Fund

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Continuity of Care Program

Participants covered through the Local 99 Health and Welfare Fund have access to the Anthem BlueCross BlueShield BlueCard PPO (“Anthem BCBS”) network. If the contract between your provider and Anthem is terminated the continuity of care protections included in the No Surprises Act may apply. A clinical review is required to confirm that you meet the definition of a continuing care patient. The services or items supplied by the provider must be covered benefits under the benefit plan and the patient must be an eligible plan participant on the date of service.

Definition of a Continuing Care Patient

Continuing care patients are defined as individuals who, with respect to the provider or facility, are at least one of the following:

- Undergoing treatment from the provider or facility for a serious and complex condition.
 - In the case of an acute illness, this means a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
 - In the case of a chronic illness or condition, this means a condition that is life threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- Undergoing a course of institutional or inpatient care from the provider or facility.
- Scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such surgery.
- Pregnant and undergoing treatment for pregnancy from the provider or facility.
- Terminally ill and receiving treatment for such illness from the provider or facility.

Rights for Continuing Care Patients

Participants requiring continuing care from a provider or facility that had their contract terminated by Anthem BCBS for a reason other than fraud or quality of care issues may be eligible for in-network benefits with this same provider through the Continuity of Care program.

The Continuity of Care program could potentially provide up to 90 days of in network benefits. To find out if you or your covered dependent qualify for this program, please refer to the enclosed form and have your physician contact Conifer Health Solutions at 877-910-3162.

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Finding a New Provider

We recommend finding a provider that participates in the Anthem BCBS network to avoid claim denials or increases in your out-of-pocket costs. For an up-to-date listing of participating providers, visit anthem.com and utilize the “Find Care” option located in the top right corner (see sample web page below).



The easiest way to search is through the “Use Member ID for Basic Search” option. Enter “LNU” for the prefix and click Continue. The website allows a variety of options for locating a provider.



Use Member ID for Basic Search

Find doctors, hospitals and more near you.

Search your medical plan without logging in.

If you need assistance locating a new provider or have any questions regarding the continuity of care program, please contact the Fund Office at 973-735-6464.

Sincerely,

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Continuity of Care Request Form

You, your current physician, or a member of your physician's staff may complete and submit the form to Conifer Health Solutions. Be sure to include the name of your physician or medical group on the form. The completed form may be faxed to 866-315-6314 or emailed to coniferclinical@coniferhealth.com.

Complete and submit a Continuity of Care Request Form if you are currently receiving or are scheduled to receive any of the following services from a provider that is leaving the Anthem BCBS network.

- Prenatal or obstetrical care
- Chemotherapy
- Radiation therapy
- Dialysis
- Home health care
- Hospice care
- Infusion therapy
- Ongoing treatment for an acute inpatient stay and related post-discharge care
- Inpatient rehabilitation
- Nonelective surgery and related post-surgical care

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Instructions

Complete this form only if you are receiving ongoing care, or are scheduled to receive care, from a provider that does not participate in your participating network. Please complete a separate form for each covered family member who needs to have care transitioned to another provider.

Member Information

Last Name	First Name	M.I	Member ID Number
Member Employer Name			

Patient Information

Last Name	First Name	M.I	Date of Birth (MMDDYYYY)
Preferred Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Secondary Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Current Primary Care Physician/Attending Physician		New Primary Care Physician/Attending Physician	
Provide the name of your doctor or hospital that is nonparticipating in the Anthem BCBS BlueCard PPO network			
Diagnosis (include pertinent history and physical findings)			

Medical Information

1. Do you have an appointment to see a specialist within the next six months? Yes No If yes, please provide the applicable information below.

Type	Physician name (last, first) and Physician phone no.	Physician Address	Date of next office visit and reason
Heart specialist	Name:		Date:
	Phone:		Reason:
Lung specialist	Name:		Date:
	Phone:		Reason:
Blood or cancer specialist	Name:		Date:
	Phone:		Reason:
Neurologist	Name:		Date:
	Phone:		Reason:
Infectious disease specialist	Name:		Date:
	Phone:		Reason:

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Type	Physician name (last, first) and Physician phone no.	Physician Address	Date of next office visit and reason
Kidney specialist	Name:		Date:
	Phone:		Reason:
Surgeon	Name:		Date:
	Phone:		Reason:
Obstetrician for pregnancy	Name:		Date:
	Phone:		Reason:
Due Date:	Hospital for Delivery:		

2. Are you currently receiving any of the following services?

Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
IV medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Home Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Rehab Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Medical Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Speech Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:
Other, please be specific	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company:

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

Date: _____ Type of Surgery/Procedure: _____
 Name/phone no. of physician performing surgery/procedure: _____
 Hospital/Facility: _____

4. Other needs/comments: Yes No If yes, please detail below

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Signature Required

I hereby authorize my provider to give Conifer Health Solutions and/or Anthem BCBS any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Continuity of Care. I understand that Conifer Health Solutions and/or Anthem BCBS may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested continuity/transition of care and need their cooperation. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information. I understand that I am entitled to a copy of this authorization form.

Signature of patient if age 18 or over	Printed Name	Date (MMDDYY)
Signature of parent or guardian if patient is under age 18	Printed Name	Date (MMDDYY)

Please have your physician fax the completed form to 866-315-6314 or email it to coniferclinical@coniferhealth.com.