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Parent Documents: Document ID of National policy			
Effective Date: See Document Information Page	Last Review Date: See Review and Revision History Section	Business Process Owner (BPO): Sr Mgr. Health Care Quality, CS Comm Reg QM	
Exhibit(s): Exhibit 1, California Traditional Transition Coverage Request Form			
Document Type: Tool			

Effective Date: 11/18/2025

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PURPOSE

This Amendment is written to meet regulatory and statutory requirements under the California Insurance Code 10133.56 that impacts NCS 600, Transition/Continuity of Care Coverage policy and procedure. This amendment will be used in conjunction with NCS 600 to comply with California requirements.

SCOPE

Applies to Department:	<input checked="" type="checkbox"/> Care Management	<input checked="" type="checkbox"/> Precertification	<input checked="" type="checkbox"/> NME Case Management
<input checked="" type="checkbox"/> 24-Hour Nurse Line	<input checked="" type="checkbox"/> DM	<input checked="" type="checkbox"/> BH	<input checked="" type="checkbox"/> Aetna Women's Health Program

Product:	<input type="checkbox"/> HMO	<input checked="" type="checkbox"/> EPO	<input checked="" type="checkbox"/> PPO	<input checked="" type="checkbox"/> MC/POS	<input type="checkbox"/> TC	<input type="checkbox"/> JV
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Applies to California members in Traditional fully insured commercial plans (includes split funding arrangements).

POLICY

A. In order to provide for continuity of care for members and in accordance with California Insurance Code 10133.56, the plan shall provide the completion of covered services for conditions listed in Section B below. Completion of the covered services shall occur in the following circumstances:

- Terminated Provider – For an insured who at the time of the provider's contract termination, was receiving services from that provider for one of the conditions described below.
- Nonparticipating provider – For a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described below.

B. The medical, mental health or substance use conditions for which the plan will provide for the completion of covered services are:

1. An acute condition. An acute condition is a medical condition that involves the sudden onset of symptoms due to an illness, injury, or other medical, mental health or substance use problem that requires prompt medical attention and that has a limited duration. **Completion of covered services shall be provided for the duration of the acute condition.**
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical, mental health or substance use problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall 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 insured and the terminated provider and consistent with good professional practice. **Completion of covered services shall not exceed 12 months from the contract termination date.**
3. A pregnancy. A pregnancy is the three (3) trimesters of pregnancy and the immediate postpartum period. **Completion of covered services shall be provided for the duration of the pregnancy.**

Maternal mental health condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

An individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider. **Completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.**

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. **Completion of covered services shall be provided for the duration of a terminal illness.**
5. The care of a newborn child between birth and age 36 months. **Completion of covered services shall not exceed 12 months from the contract termination.**
6. Performance of a surgery or other procedure that is authorized by the insurer as part of a documented course of treatment and has been recommended and documented by the provider to occur **within 180 days of the contract's termination or 180 days of the effective date of coverage for a newly covered enrollee.**

The policy shall not apply to an enrollee who is offered an out-of-network option.

C. Contractual Considerations

1. The amount of, and the requirement for payment of, co-payments, deductibles, or other cost-sharing components by the insured during the period of completion of covered services with a terminated provider shall be the same co-payments, deductibles and other cost-sharing components that would be paid by the insured when receiving care from a provider currently contracting with the plan.
2. The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, then the insurer is not required to continue the provider's services beyond the contract termination date.
3. The plan may require a **non-participating** provider whose services are continued for a newly covered insured to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently participating providers providing similar services who are practicing in the same or a new similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue to the provider services.
4. Unless otherwise agreed upon by the terminated or **nonparticipating** provider and the plan, the services rendered shall be compensated at rates and methods of payment similar to those used by the insurer for currently participating provider providing similar services who are practicing in the same or similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of the nonparticipating provider if the provider does not accept the payment rates. The provider who agrees to provide services shall accept the reimbursement as payment in full and shall not bill the plan for any amount in excess of the reimbursement rate, with the exception of copayments and deductibles

D. The plan is not required to provide for the completion of covered services in the following instances:

1. For a provider whose contract with the insurer or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

2. For services or benefits that are not otherwise covered under the terms and conditions of the insurer contract.
3. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, then the insurer is not required to continue the provider's services beyond the contract termination date.
4. Neither the plan nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

E. Additional Considerations and Requirements

1. The provisions contained in this policy are in addition to any other responsibilities of the plan to provide continuity of care. Nothing in this policy shall preclude the plan from providing continuity of care beyond the requirements of this section.
2. Decisions regarding Transition Coverage Requests are made within two (2) business days of obtaining all necessary information. Necessary information includes a completed Transition of Care form and information required by the form. The provider is notified telephonically within twenty-four (24) hours of the decision. The insured and the terminated provider are notified of the decision in writing within two (2) business days of the decision. If services were received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new plan level. The Medical Director considers delays incurred by the Plan which may have affected the insured's receipt of services prior to the approval of transition coverage.
3. As communicated in the Evidence of Coverage and Disclosure Notice, the plan provides all new insureds with notice of this policy as well as how to request a Transition of Care review. The insured must request a Transition Coverage Request Form by calling the Member Services telephone number listed on the ID card. The form must be completed by the insured. Request Forms may also be obtained from the insured's employer.
4. The plan shall provide a written copy of this policy to its insureds upon request. Members may request a copy of the information by calling the Member Services telephone number listed on the ID card and requesting a copy of the Transition of Care Coverage Policy.
5. If the plan delegates the responsibility of complying with these requirements to a provider group and/or its contracting entities, then the plan shall ensure that all requirements are met.

6. The plan is not required to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.
7. The plan shall provide a written copy of this information to its contracting providers and provider groups.

STATE DEFINITIONS

- CA Insurance Code: "Terminated provider" means a provider whose contract to provide services to insureds is terminated or not renewed by the insurer or one of the insurer's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the insurer or contracting provider group.
- CA Insurance Code: "Provider" means a person who is a licentiate as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

EXHIBIT(S): Exhibit 1, California Traditional Transition Coverage Request Form



Transition/Continuity of Care Coverage Request

ECHS Category - TCRF

Personal and confidential

*This form applies to fully insured commercial Traditional
(non-HMO) members in California*

Here's the form you requested for transition/continuity of care coverage from the health plan. If we approve your request, the health plan will cover ongoing care at the highest level of benefits from:

- An out-of-network doctor
- A doctor whose network status has changed
- Certain other health care providers who have treated you

Once we review your completed form, we'll send you a letter explaining our decision.

Some things you should know about transition/continuity of care coverage

You'll find answers to commonly asked questions about transition-of-care/continuity of care coverage on the other side of this form.

You should read them before filling out this form.

Transition/continuity of care coverage does not apply if your provider is in the plan's network (participating) or is part of your plan's highest benefit tier. The online provider search directory is found on the health plan's webpage. It can tell you if your doctor is in the network or help you find a participating provider for your health plan. You can also call us at the phone number on your ID card.

How to complete the form and get it to us

Step 1: Fill out these sections:

1. Section 1 (Plan information) Plan information is on the front of your ID card.
2. Section 2 (Subscriber and patient information):
3. Section 3 (Authorization): Read the authorization, then sign and date the form.

Step 2: Give the form to the doctor/health care provider to complete **Section 4 on page 4**, including the diagnostic and treatment information requested on **page 5**.

Step 3: **Fax** the completed form to us for review. You can mail the completed form to the address listed on your ID card. You should complete one form for each health care provider.

Step 4: You can also submit a digital copy of the forms by visiting your member website at [Aetna.com](https://www.aetna.com). Once you sign in, click **Support > Contact Us > Send a Message**. From the Message Center, click **New Message > Send Message**. From here, choose the message topic "**Other**" and load your completed forms

Fax medical and mental health/substance use requests to 1-859-455-8650.

Be sure to complete all fields on page 4 and 5 before you submit this request form.

Your request will be answered faster that way.

Transition/Continuity of care coverage questions and answers

California Commercial Traditional Fully Insured Products

Q. What is California transition/continuity of care (TOC/COC) coverage?

A. For new members:

TOC/COC coverage is temporary. You can get TOC/COC when you become a new member of a medical benefits plan or change your plan, and you are being treated for a medical, mental health or substance use condition by a doctor who:

- Is not in the plan's network; or
- Is not included in Narrow Network, or a plan sponsor specific network, and your benefits change to include one of these networks

TOC/COC coverage applies to the following types of providers: individual practitioners, medical groups, independent practice associations, acute care hospitals, or institutions licensed in California to deliver or furnish health care services. Examples of individual practitioners include doctors, psychiatrists, licensed therapists and qualified autism service providers, professionals or paraprofessionals.

For existing members:

TOC/COC coverage can also apply when your doctor or facility leaves the plan's network or changes network status. Approved TOC/COC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

TOC/COC coverage applies to the following types of providers: individual practitioners, medical groups, independent practice associations, acute care hospitals, or institutions licensed in California to provide health care services. Examples of individual practitioners include doctors, psychiatrists, licensed therapists and qualified autism service providers, professionals or paraprofessionals.

TOC/COC coverage for new or existing members does not include durable medical equipment (DME) vendors or pharmaceutical items. If we approve TOC coverage, the doctor must use a DME vendor or pharmacy vendor in the plan's network. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

Q. What is an active course of treatment?

A. An active course of treatment means you have been receiving services from your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some active course of treatment examples may include but are not limited to members who:

- Are pregnant and has begun a course of treatment (including prenatal care) for the pregnancy from the provider or facility. Pregnancy is the three trimesters of pregnancy and the immediate postpartum period.
 - Maternal mental health condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
 - An individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, **completion of covered services for the maternal mental health condition shall be provided 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.**
- Have an acute condition that involves the sudden onset of symptoms due to an illness, injury, acute, 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.
- Are authorized to undergo a surgery or procedure from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery. The documentation must show that the provider recommends the treatment to occur within 180 days of the provider's contract termination date or within 180 days after the effective date of the newly covered enrollee.
- Have a terminal illness that is an incurable or irreversible condition and has a high probability of causing death within one year or less. Completion of covered services will be provided for the duration of the terminal illness.
- Have an on-going or disabling medical condition or serious or chronic 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 or terminated provider, and consistent with good professional practice. Coverage will not exceed 12 months from the contract termination date or 12 months from the effective date of a newly covered enrollee.

- Are undergoing a course of treatment for a serious and complex condition from a provider or facility such as chemotherapy or radiation therapy
- Are receiving any services related to the care of a child ages 0-36 months up to 12 months from the provider's contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
- May need or have an organ or bone marrow transplant

Q. Do I need to complete a form for each provider that I am requesting TOC/COC for?

A. Yes, a separate form is required for each provider.

Q. What other types of providers, besides doctors, can be considered for TOC/COC coverage?

A. TOC/COC coverage may also apply to physical therapists, occupational therapists, speech therapists, and agencies that provide skilled home care services such as visiting nurses. TOC/COC is considered for participating hospitals when the facility is not designated for the highest benefit level for plans that include tiered networks or when a participating facility terminates from the network. Providers considered for transition coverage may vary by condition, as described above, in accordance with California law. California TOC/COC coverage does not apply to durable medical equipment (DME) vendors or pharmaceutical items.

Q. If I am currently receiving treatment from my doctor, why wouldn't you approve my request for California TOC/COC coverage?

A. To be approved for TOC/COC, the procedure or service must be a covered benefit under the terms of your plan. **For providers that leave the network**, your doctor must accept the terms outlined on the TOC/COC request form.

Q. My PCP is no longer a participating provider. If my plan requires me to select a PCP, can I still see my doctor?

A. If you're currently receiving treatment (as described above), you may still be able to visit your PCP, even if your PCP leaves the network. If not, you may need to select a PCP in the health plan's network. Talk to your PCP for help you with your future health care needs.

Q. How do I sign up for TOC/COC coverage?

A. Contact the Member Services number on your member ID Card. You must submit a TOC/COC request form to the health plan:

- Within 90 days of when you enroll or re-enroll
- Within 90 days of the date the health care provider left the plan's network or within 90 days from the date on the letter notifying you of the change
- Within 90 days of a doctor's network status change

You or your doctor can send in the request form

Q. Does TOC/COC coverage apply if my plan does not have a provider network?

A. No.

Q. What if I have a Narrow Network or plan sponsor specific network plan?

A. If we approve your TOC/COC coverage, you may still receive care at the highest benefits level for a certain time period. If you continue treatment with this doctor after the approved time period, your coverage would be limited to what your plan allows. This means you may have reduced benefits or no benefits.

Q. What if I have more questions about TOC/COC coverage?

A. Call the Member Services phone number on your ID card. If you have questions about TOC/COC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health or behavioral health phone number.

Q. How will I know if my request for TOC/COC coverage is approved?

A. We will make a decision after we receive your request. We will send you a letter via U.S. mail. The letter will say whether or not you are approved.



Transition/Continuity of Care Coverage Request

ECHS Category - TCRF

Personal and confidential

This form applies to fully insured commercial Traditional (non-HMO) members in California

Medical Mental health/substance use

Please indicate above whether this request is for medical treatment or mental health/substance use treatment.

Form completed by: Member Provider

Please complete this form to the best of your ability. Your request for continued coverage will not be denied if sections are left blank or your treating provider does not fill out the form.

1. Group or employer information (Note: Please complete a separate form for each member and/or provider.)

Plan name (please print)	Plan number (s)	Plan effective date
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2. Subscriber and patient information

Subscriber's name (please print)	Subscriber's ID number	
Subscriber's address (please print)		
Patient's name (please print)	Birthdate (MM/DD/YYYY)	Telephone number
Patient's address (please print)	Plan type/product	
	Telephone number for patient/subscriber submitting request (Business hours, 9 a.m. – 5 p.m.)	
Request for Transition/Continuity of Care Coverage due to: New member: <input type="checkbox"/> Yes <input type="checkbox"/> No Provider termination: <input type="checkbox"/> Yes <input type="checkbox"/> No If provider termination, please provide the date of the letter notifying you of the provider terminating from the network and include a copy of the letter with the completed form. (MM/DD/YYYY)		

3. Authorization

I request approval for coverage of ongoing care from the healthcare provider named below for treatment started before my effective date with the health plan, or before the end of the provider's contract with the health plan's network, or before the provider's network status change. If approved, I understand that the authorization for coverage of services stated below will be valid for a certain limited period of time. I give permission for the health care provider to send any needed medical information and/or records to the health plan so a decision can be made.	
Patient's signature (required if patient is 17 or older)	Date (MM/DD/YYYY)
Parent's signature (required if patient is 16 or younger)	Date (MM/DD/YYYY)

4. Provider information – (Note: Provide all specific information to avoid delay in the processing of this request.)

Name of treating doctor or other health care provider (please print)	Tax ID number
Service Address of treating doctor or other health care provider (please print)	
Contact name of office personnel to call with questions	Telephone number
Signature of treating doctor or other health care provider	Date (MM/DD/YYYY)

The above-named patient is a member as of the effective date indicated above. We understand you are not or soon will not be a participating provider in the health plan's network. The patient has asked that we cover your care for a specific time period. This is because of a condition, such as pregnancy, that is considered an active course of treatment. An active course of treatment is defined as: "A program of planned services starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment and includes a qualifying situation". Please include a brief statement of the patient's current condition and treatment plan. For pregnancies, please indicate the estimated date of confinement (EDC). If we approve this request, you agree:

- To provide the patient's treatment and follow-up
- Not seek more payment from this patient other than the patient responsibility under the patient's plan of benefits (for example, patient's copayment, deductibles or other out-of-pocket requirements)
- To share information on the patient's treatment with us

You also agree to use the health plan's network for any referrals, lab work or hospitalizations for services not part of the requested treatment.

Transition/Continuity Coverage Request

ECCHS Category - TCRF

Personal and confidential

Patient's name (please print)	Birthdate (MM/DD/YYYY)
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Please complete the diagnostic and treatment information below describing the active course of treatment and attach all clinical documentation to support this request.

ONCOLOGY

Are you in a current course of active treatment (Reconstruction Surgery, Radiation Therapy, Immunotherapy, Targeted Agents, **OR** Chemotherapy) for Cancer with treatment initiated in the last 90 days?

Yes No Name of drug: _____ DX and description: _____

Expected length of treatment: _____ Visit and next Visit Dates: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

INTRAVENOUS THERAPY COURSE OF TREATMENT REQUEST

Is the member currently receiving intravenous therapy for Antibiotics, **OR** Hyperalimentation/Total Parenteral Nutrition?

Yes No Treatment Start Date: (mm/dd/yyyy): _____ and Expected End Date: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

SURGICAL FOLLOW-UP REQUEST (POST-OP)

Is this a follow-up with a Surgeon's office and is the member within the 90 days post-operative period **OR** has the member started a series of surgical procedures to correct the same condition?

Yes No Date of Surgery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OBSTETRICAL REQUEST

Is the member pregnant and has completed her first visit with an Obstetrician (OB) office?

Yes No First OB Visit: (mm/dd/yyyy): _____ Expected Date of Delivery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OTHER REQUESTS

Is the member currently in an active course of treatment?

Type of treatment: _____

Treatment Start Date: (mm/dd/yyyy): _____ Last Date of Treatment: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

Misrepresentation: Attention California residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Discrimination is Against the Law

Aetna complies with applicable California and Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnic group, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, medical condition, genetic information, or sex (consistent with 45 CFR § 92.101(a)(2) and California 2 CCR § 14025). Aetna does not exclude people or treat them less favorably because of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability.

Aetna:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified sign language interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call [1-800-872-3862](tel:1-800-872-3862) (TTY: [711](tel:711)) or the number on the back of your ID card.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, medical condition, genetic information, or disability, by action or inaction, you can file a grievance with:

Civil Rights Coordinator Attn: 1557

Coordinator CVS Pharmacy, Inc.

1 CVS Drive, MC 2332, (HMO customers: P.O. Box 14032 Lexington, KY 40512-4032)

Woonsocket, RI 02895

Phone: [1-800-648-7817](tel:1-800-648-7817), TTY: [711](tel:711)

Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Please visit <https://www.aetna.com/individuals-families/member-rights-resources/complaints-grievances-appeals.html#california> for information about how to file a complaint or grievance with the California Department of Insurance or California Department of Managed Health Care (for HMO enrollees).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F,

HHH Building Washington, D.C. 20201

[1-800-368-1019](tel:1-800-368-1019), [800-537-7697](tel:800-537-7697) (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. This notice is available at Aetna's website: <https://www.aetna.com/>

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