Midwest Operating Engineers Welfare Fund

Continuity of Care (COC) - Frequently Asked Questions

Background
In accordance with the Consolidated Appropriations Act, 2021 (CAA) which included the No Surprises Act (NSA) regulations, the Midwest Operating Engineers Welfare Fund (the "Plan") must comply with the Continuity of Care provisions. The Continuity of Care provisions are effective for services received on or after April 1, 2022.

The following Frequently Asked Questions may assist you with understanding your rights and how the rules work relating to Continuity of Care (COC).

What is Continuity of Care (COC)?
The term COC may mean that the provider left the Plan's current network or the Plan changed benefits because the provider or facility left the network. In general, once a provider or facility leaves the network, patients may pay more because the claim is considered out-of-network on the date notice is provided for up to 90 days, **if the patient meets the requirements and elects COC coverage, and elects temporary coverage, the associated claims for the facility or provider will be processed as though they are in-network for up to 90 days.**

Who will notify the patient that the facility or provider is terminating their in-network status?
The patient will receive a letter from the Fund Office regarding the COC coverage.

What will the patient be required to do?
Along with the letter to the patient, the Fund Office will send you a COC Election Form to complete. **The COC Election Form must be completed regardless of whether the patient elects COC coverage or not.**

How does a patient qualify for COC coverage under the NSA?
The patient must meet the requirements of a "Continuing Care Patient", as listed below.

How is a patient categorized as a "Continuing Care Patient"?
The term "Continuing Care Patient", with respect to a facility or provider:
- ✓ Is undergoing treatment for a serious and complex medical condition, or
- ✓ Is undergoing a course of institutional or inpatient care from the provider or facility, or
- ✓ Is scheduled to undergo nonelective surgery from the provider, including postoperative care from the provider or facility with respect to such surgery, or
- ✓ Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility, or
- ✓ Is or was determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

Please Note: A Valenz Case Manager may contact you to obtain medical records for clinical review.

What is considered a serious and complex medical condition?
- In the case of an acute illness, a condition that is serious enough to require a specialized medical treatment to avoid the possibility of death or permanent harm, or
- In the case of a chronic illness or condition, a condition that is:
  - ✓ life threatening, degenerative, potentially disabling, or congenital, AND
  - ✓ requires specialized medical care over a prolonged period of time.

Continuity of Care (COC) - Frequently Asked Questions (continued)

How is terminally ill defined?
An individual is considered terminally ill if the medical prognosis for that individual's life expectancy is six months or less (Social Security Act).

If a patient qualifies as a "Continuing Care Patient" and elects COC coverage, how will the patient's claims be processed?
During the temporary transition of care, the claims associated with the Covered Services received from the facility or provider will be considered as in-network instead of out-of-network. **Please Note:** The temporary transition of care can be up to 90 days or less. If the patient continues to seek treatment from the facility or providers after the patient is no longer entitled to receive treatment on an in-network basis, , the claims will be processed out-of-network, resulting in an increased cost-sharing by the patient. The patient can contact Member Services at (708) 579-6600 to seek assistance in searching for a facility or provider that is in-network to decrease the patient's cost-sharing.

If a patient qualifies as a "Continuing Care Patient" and does not elect COC coverage, how will the patient's claims be processed?
The patient can continue to receive treatment from the facility and/or provider. However, any claims associated with the Covered Services received from the facility or provider will considered out-of-network, resulting in an increased cost-sharing by the patient.

What if a patient does not qualify as a "Continuing Care Patient"? The regulations under the NSA COC will not apply. The patient can continue to receive treatment from the facility and/or provider. However, any claims associated with the Covered Services received from the facility or provider will be considered out-of-network, if available, resulting in an increased cost-sharing by the patient. The patient can contact Member Services at (708) 579-6600 to seek assistance in searching for a facility or provider that is in-network to decrease the patient's cost-sharing.