

The following is the information referenced in the Fall 2009 Provider Report.

MEMBER RIGHTS

UHP members have the right to:

- Receive high quality healthcare from caring, responsible, and competent healthcare providers.
- Receive healthcare services regardless of age, race, sex, creed, color, religion, nationality, or sexual orientation.
- Have medical problems and treatment options explained fully and clearly so the member will be able to give an informed consent to the treatments and/or procedures suggested by their healthcare provider.
- Upon request to receive a copy of their medical records, and request that they be amended or corrected.
- Consent to releasing medical records only after the member has voluntarily signed a release form.
- Refuse treatment, to the extent permitted by law, and be clearly informed of the medical consequences of their refusal.
- Ask questions and receive up-to-date information regarding their health, health problems, and medical treatment(s) from their healthcare providers.
- Obtain experimental treatment for life-threatening or serious illnesses for which no standard treatment has been effective. Members will be able to receive experimental treatment as a covered benefit if said treatment has been qualified through an approved clinical trial.
- Speak with their provider in private and have their medical records kept confidential.
- Participate in decision making regarding their healthcare, including second opinions.
- Make recommendations regarding UHP's member rights and responsibilities.
- Provide for "Advance Directives" or "Living Wills" so that their wishes regarding their healthcare are known if they are unable to make decisions about their care.
- Disenroll from UHP as follows:
 - Medicaid or NJ FamilyCare Plan A members
 - For good cause at any time
 - Within the first three months of enrollment
 - After one year of enrollment and every year thereafter for any reason
 - If they are enrolled through SSI or are an ABD or DYFS member, they may disenroll at any time
 - NJ FamilyCare Plan B, C, or D members
 - For good cause at any time
 - After one year of enrollment and every year thereafter for any reason
- Have their concerns, suggestions, or complaints registered with a Member Services representative and have them acknowledged in writing within fifteen (15) days.
- File a formal grievance.

- Receive a summary of survey results, if applicable.
- Be given stop-loss information. Stop-loss is insurance that UHP has to cover very high hospital bills.
- Have no prohibition on communications with or from providers. Doctors are free to discuss all medical treatment options even if they are not covered services.
- Have the health status survey on their application communicated to UHP by the Health Benefits Coordinator.
- To be treated with dignity, respect and privacy from UHP staff, providers, physicians and their office staff.
- Receive information regarding UHP's services, products, providers, hospitals, policies and procedures and appeal procedures.
- Receive care in a hospital for at least 48 hours after delivering a child vaginally, or at least 96 hours after a Caesarean section delivery.
- A second opinion from a qualified healthcare professional.
- Obtain a current provider directory.
- Make suggestions for changes to policies and procedures.
- A choice of specialists and a description of the referral process for specialty and ancillary care and second opinions.
- Obtain a standing referral and be informed of the circumstances under which such action may be taken.
- Have access to a PCP or back-up 24 hours a day, 365 days a year for urgent care.
- Call 911 in a potential life-threatening situation without prior approval from UHP.
- Be free from balance billing.
- Contact Department of Banking and Insurance (DOBI) at 609-292-5316 and Department of Human Services (DHS) at 1-800-356-1561, if dissatisfied with UHP's resolution to a complaint.
- Have UHP pay for a medical screening exam in the emergency room to determine whether an emergency exists.
- Receive up to four (4) months of coverage, if medically necessary, from a doctor who has been terminated from UHP and longer in the following cases: Pregnancy (up to six (6) weeks after delivery); Post-Op (up to six (6) months); Oncology (up to one (1) year); and Psych (up to one (1) year).
- Right to access emergency services in-network or out-of-network without prior approval from UHP.
- Know how UHP pays its doctors. UHP does offer a physician incentive plan to their providers that affects the use of referral services.
- Have a doctor make the decision to deny or limit a member's coverage.
- Appeal a decision to deny or limit coverage, first within UHP and then through an independent organization for a filing fee. Have appeal and grievance decisions communicated to them in their primary language.
- A member or provider cannot be penalized for filing a complaint or appeal.
- Aged, Blind & Disabled (ABD) enrollees have the right to disenroll from UHP at any time.
- Make decisions about their healthcare based upon physical, cultural, linguistic and religious beliefs.

- Change their PCP without cause up to three times per year by contacting UHP Member Services at 1-800-564-6847. They may be asked to select another PCP if the provider they want to select has a closed panel.
- To have a representative or another authorized person to assist them in the selection of their PCP.
- To follow their instructions for care agreed upon by them and their physician or hospital.
- To give information about themselves to the UHP organization, providers, physicians and hospitals in order to help set treatment goals.

RIGHTS OF MINORS

For any member under 18 years of age, the parent or legal guardian must first approve the healthcare services that the member receives. However, minors have the right, under certain conditions and as permitted by law, to receive healthcare treatment without the approval of their parent or legal guardian. For example, pregnant teenagers may receive treatment without first obtaining parental/guardian approval. Minors may also receive family planning from their UHP PCP with or without parental consent. In an emergency, when approval cannot be obtained, emergency services may be provided.

MEMBER RESPONSIBILITIES

UHP members are responsible for:

- Notifying UHP or NJ FamilyCare at 1-800-701-0710 of all their physician/patient relationships that existed prior to enrollment with UHP.
- Making an appointment to see a UHP PCP immediately after joining.
- Visiting their PCP regularly, not only when they're sick, and following their PCP's advice and keeping their PCP fully informed after receiving hospital or emergency room services.
- Their PCP may request that a member be reassigned to a different PCP if they do not follow his or her medical advice or instructions, act abusively, or have taken legal action against him or her.
- Keeping appointments.
- Approving the treatment of their minor children if they are a parent or legal guardian.
- Using the hospital emergency room only for life-threatening emergencies.
- Going to their UHP PCP for all their healthcare needs.
- Calling UHP Member Services at 1-800-564-6847 with any questions about how to use the services covered by UHP.
- Notifying UHP of any changes in aid status, dependents, employment, address or telephone number. Please note that moving outside UHP's service area may require disenrollment from UHP.
- Returning their UHP membership ID card to UHP on the date the coverage with UHP ends.

- Following UHP's rules and policies, such as getting a prior authorization from their PCP before obtaining healthcare services from any other provider. If they do not follow this rule, a member may be billed for the services received.
- Signing the application form, which authorizes the lawful release of medical history and healthcare records for them and their applicable family members to any person(s) who provide them with healthcare as long as they are UHP members.
- Plan C and D members: Keeping track of the copays they pay each year. They must notify UHP Member Services at 1-800-564-6487 if the total exceeds 5% of their income for the year. They must also notify NJ FamilyCare at 1-800-701-0710. If their copays exceed 5% in any year, they are not required to make additional copays for the rest of that year.
- Notifying UHP of their Third Party Liability (TPL) resources for potential payment of medical and dental services. A source of TPL can be Medicare, a commercial health insurance policy or casualty insurance. Casualty insurance includes no fault auto insurance benefits, workers' compensation benefits or medical payments made through a homeowner's policy.
- UHP, in conjunction with its management company, Centene Corporation, successfully operates a billing errors/waste, abuse and fraud unit. If they suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. UHP and/or Centene take all reports of potential waste, abuse or fraud very seriously and investigates all reported issues.

NEW TECHNOLOGY

UHP provides coverage for medical services or procedures that are not considered investigational or experimental. UHP evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and or Medical Management staff may identify relevant topics for review pertinent to our population. The Centene Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

In the instance where the request is made for coverage for new technology, which has not been reviewed by the CPC, the UHP Medical Director will review all information and make a one-time determination within two working days of receipt of all information. This new technology request will then be reviewed at the next regular meeting of the CPC. If you are aware of a new technology and would like a benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-800-429-4585.

AFFIRMATIVE STATEMENT FOR UTILIZATION MANAGEMENT

All individuals involved in UM decision-making at UHP are asked to sign an Affirmative Statement about incentives and acknowledge that UHP makes UM decisions based on appropriateness of care and existence of coverage. UHP does not reward practitioners or other individuals for issuing denials of coverage or service care or financial incentives for UM decision-makers to encourage underutilization. UHP staff receive this statement upon hire and annually thereafter. This statement is distributed upon initial contracting with practitioners and providers via the Provider Manual and annually thereafter to all network providers via our Provider Newsletter.

TRANSITION PLANNING

UHP ensures that any new member identified (either by the information on the Plan Selection Form at the time of enrollment or by providers after enrollment) as having complex/chronic conditions receives immediate transition planning. The planning is completed within a timeframe appropriate to the member's condition, but in no case later than ten (10) business days from the effective date of enrollment when the Plan Selection Form has an indication of special health care needs or within thirty (30) days after special conditions are identified by a provider. Transition planning provides for a brief, interim plan to ensure uninterrupted services until a more detailed plan of care is developed. The transition planning process includes, but is not limited to:

- Review of existing care plans.
- Preparation of a transition plan that ensures continuous care during the transfer into the UHP network.
- If durable medical equipment had been ordered prior to enrollment but not received by the time of enrollment, UHP must coordinate and follow-through to ensure that the enrollee receives necessary equipment.

ASTHMA PROGRAM

This program targets UHP members who have been diagnosed and treated with medications for asthma for additional case/care management and support from the medical management department. Additional education and coordination of care with the member's PCP is a key factor in this program. The goals of this program include increasing positive clinical outcomes for the member and controlling the asthma in order to improve the quality of life for the member.

COPD PROGRAM

UHP's Healthy Solutions for Life Program also helps members with COPD who may be in this program at no cost.

HEALTH MANAGEMENT PROGRAMS

As a part of the UHP medical management quality improvement efforts, medical management

programs are offered to members. Some of the programs available to UHP members include:

START SMART FOR YOUR BABY PRE-NATAL PROGRAM

START SMART for Your Baby is a pre-natal program that blends healthcare, health education, and environmental modifications in an effort to improve the outcome of the member's pregnancy.

The goals of this program for members are to:

- Attend all required visits with the PCP/OB
- Work with the pre-natal care coordinator
- Eat healthy foods
- Avoid alcoholic beverages
- Avoid/decrease tobacco use
- Avoid illegal drug consumption
- Receive dental care

DIABETES MANAGEMENT PROGRAM

This program targets UHP members who have been diagnosed and treated for diabetes mellitus. Through this program, UHP members can receive additional education, case/care management and support from the medical management team to enhance positive clinical outcomes.

CARE MANAGEMENT PROGRAM FOR SPECIAL NEEDS

The Care Management Program will ensure that members with special needs will have the same access to quality care as other members. Members with special needs may be:

- Adults with a medical condition that requires special healthcare services. These adults may have physical, mental, substance abuse, and/or developmental disabilities. These adults may also be homeless.
- Children with special healthcare needs are those who have, or are at increased risk for, a chronic physical, developmental, behavioral or emotional condition. This includes children who need health and related services of a type or amount beyond those required by most children.

The Care Management Program for UHP's enrollees with Special Needs consists of the following:

Care Plans specifically developed for each member with special needs, which ensure continuity and coordination of care among the various clinical and non-clinical disciplines and services. A process to evaluate and improve individual care management services as well as the effectiveness of care management as a whole.

Protocols for the following care management activities:

- Coordination of Dental/Medical Services for members
- Initiation/Coordination of social services to improve member's health status

- Pregnancy services including Health Start Program requirements
- All EPSDT services and coordination for children with elevated blood lead levels
- Mental Health/substance abuse/HIV/AIDS services coordination

Members who need Complex Needs Assessment will be identified in several ways such as but not limited to utilization data, information provided on the enrollment application, or at the request of a member, authorized person, or their PCP.

TREATMENT ALTERNATIVES

UHP is committed to providing the best possible care to our members. UHP affords its members certain rights and responsibilities assisting them in seeking this care from participating providers. Members have a right to be informed of their healthcare treatment program, and any available alternatives, as defined by you, the provider.

It is important that you engage in the following with UHP members:

- Explaining medical problems and treatment options, in easy to-understand language, thus allowing the member to file an informed consent to the treatments and/or procedures.
- Responding to any member with questions about their health, health problems and medical treatments in a clear and concise fashion.
- Allowing members to actively participate in the decision making process regarding their healthcare, including second opinions.
- Free and open communication with members to discuss all treatment options, even if they are not covered services.

Member satisfaction surveys are conducted periodically to assess members' ability to exercise these rights when accessing care from participating providers.