



**UHP**

**University Health Plans,**  
*The Smart Decision.*

**NJ FamilyCare**

**Member Handbook**

**University Health Plans, Inc.**  
**550 Broad Street, 17<sup>th</sup> Floor**  
**Newark, New Jersey 07102**  
**1-800-JOIN-UHP**  
**1-800-564-6847**

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# UNIVERSITY HEALTH PLANS, INC.

## NJ FAMILYCARE MEMBER HANDBOOK

*Healthy Families Start Here*

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## *Welcome to University Health Plans*

Welcome to University Health Plans, Inc. (UHP). University Health Plans is a managed health care plan that promotes early diagnosis and treatment through a network of doctors, hospitals, referral specialists and other providers. You may choose one of our contracted doctors or other licensed providers as your Primary Care Providers (PCP). Your PCP will be responsible for providing your health care, arranging referrals and monitoring your health. University Health Plans will provide you with high quality health care coverage and access to an organized system of health services. We encourage you to make an appointment with your Primary Care Provider (PCP) as soon as possible to have a baseline physical examination.

We are pleased that you have enrolled in University Health Plans. You are receiving this handbook as part of the New Member Packet. The New Member Packet also contains important documents including your University Health Plans ID Card that you will need to receive health care services, a list of participating hospitals and pharmacies, and an invitation to our next scheduled Member Orientation Program, as well as other important information. Your expected effective date of coverage is indicated on your UHP ID card. There may be a delay from 30 to 45 days from the time of your initial application and your effective date in UHP. Please note there maybe a delay to 30 -45 days between the date of the request for disenrollment and effective date of disenrollement. During this interim period, you are still eligible to receive benefits under the Medicaid fee-for-service program.

We have prepared this handbook to help you understand the services University Health Plans offers to you and your family, if applicable. This handbook describes what services are covered, where to receive services and how to use the plan. Please keep this handbook in a convenient location. Important changes to the plan or your benefits not contained in this handbook will be communicated to you within 30 days from the date of the change.

Please read this handbook carefully. If you have any questions, please call a University Health Plans Member Services Representative at 1-800-JOIN-UHP (1-800-564-6847) Monday through Friday from 9 a.m. to 5 p.m. After 5 p.m., on holidays, and on weekends, your call will be answered by an operator. If your call is about a non-medical question, the operator will suggest that you call during regular business hours. If you have a medical problem, the operator will assist you in contacting your Primary Care Provider.

The University Health Plans Member Handbook is available in Spanish. Please contact UHP at:  
**1-800-JOIN-UHP (1-800-564-6847).**

El manual para los miembros de University Health Plans se puede obtener en español.  
Por favor comuniqués con UHP por el teléfono 1-800-JOIN-UHP (1-800-564-6847).

We thank you for choosing University Health Plans. We look forward to serving your health care coverage needs.

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## Health Services and Benefits Available Through University Health Plans

- Your own PCP whom you may select to manage your health care. You choose your PCP from UHP's list of Participating Providers. You may choose a doctor or a licensed nurse practitioner as your/or your child's Primary Care Provider. You may choose different PCP's for eligible family members if you wish.
- Your own dentist whom you may select from UHP's list of participating dentists. Referrals are not required for preventive dental care. Plan D Dental Services are limited to preventive dental service for children under the age of 12 years, including oral exams, oral prophylaxis, and topical application of fluorides.
- Regular preventive health care visits with health care providers, including immunizations and well baby care.
- Specialist care, diagnosis and treatment when ordered by your University Health Plans contracted Provider and pre-authorized by UHP, when applicable.
- Laboratory tests, x-rays and other diagnostic procedures (routine testing related to administration of clozapine and other psychotropic drugs for non-Division of Developmental Disabilities (DDD) Beneficiaries are excluded, but covered under the Medicaid fee-for-service program).
- Radiology services diagnostic and therapeutic.
- Emergency medical care and primary care services, including certified nurse mid-wives, nurse practitioners, clinical nurse specialist, physician's assistance services and independent clinic services, are available twenty-four (24) hours a day, seven (7) days a week.
- In-patient hospital care, including all medical services, equipment and supplies ordered by your health care provider.
- In-patient rehabilitation services.
- Mental health/substance abuse services for beneficiaries of the Division of Developmental Disabilities/(DDD), including the DDD/Community Care Waiver.
- Outpatient hospital services.
- Post acute care.
- Prescription drugs and some over-the-counter drugs.
- Eye examinations and select eye wear at participating UHP vision care providers. Referrals are not required. (Plan D limits one routine eye examination per year and limited to one pair of contact lenses per 24 month period, or as medically necessary.)
- Audiology services, not covered for FamilyCare Plan D.
- Hearing testing and hearing aid services. (Not covered for FamilyCare Plan D)
- Podiatrist services. (Excludes routine hygienic care of the feet.)
- Home Health Agency Services, Plan D covered for skilled nursing services only, (excludes non-dually eligible aged, blind, and disabled (ABDs).
- Prenatal (Pregnancy) and maternity care.
- Family planning services and supplies.
- Durable medical equipment. (Not covered for Plan D)
- Transportation services including ambulance, medical intensive care units (MICUs), and invalid coach. (Invalid coach and lower mode transportation is not covered for Plan D members.)
- Nutrition counseling.
- Hospice agency services.
- Prosthetic, orthotics, (prosthetics are limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or

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congenital defect. Repair and replacement services are covered when due to congenital growth. Orthotic devices are not included for Plan D.

- Organ transplants including liver, lung, heart/lung, kidney, cornea, intestine, bone marrow, and autologous transplants. (Excludes experimental organ transplants.)
- Chiropractor services. (Not covered for NJ FamilyCare Plan D)
- Early and periodic screening, diagnosis and treatment (EPSDT) program services including non-legend drugs, ventilator services in the home, and private duty nursing when indicated as a result of EPSDT screening, including lead screening. For NJ FamilyCare plans B and C participants coverage is limited to early and periodic screening and diagnosis, medical examinations, dental, vision, hearing, and lead screening services. Includes on those treatment services identified through the examination that are available under UHP's benefit package of specified services under the fee for service program. For NJ FamilyCare D recipients, coverage is limited to well child care, including immunizations and lead screening. Private duty nursing is included only when authorized by UHP.
- Healthcare counseling and health promotional programs, including wellness programs for asthma, pregnancy, diabetes, HIV-AIDS, and smoking cessation are also available through your PCP, or the plan.
- Members received quarterly newsletters informing and educating them about healthy life-styles and important health topics.

These services are provided based upon Medical Necessity without planned limits unless noted.

If you are unsure whether a service is covered, please call University Health Plans at 1-800-JOIN-UHP (1-800-564-6847). (Note: This handbook is intended to give the reader a general summary of benefits. The New Jersey Care 2000+ Contract is the controlling document.)

## **Second Opinion Program**

A member may seek at his or her discretion, a second opinion for the diagnosis and treatment of any serious medical or surgical condition (for example, cancer) which he/she chooses to substantiate or obtain an alternative method of treatment. To arrange for a second opinion, call UHP Member Services at 1-800-JOIN-UHP or ask your PCP to arrange a second opinion for you.

## **WIC Program**

**WIC** is the special supplemental nutrition program for **W**omen, **I**nfants, and **C**hildren.

Members may self refer or can be referred by their provider to the nearest WIC office.

Women (pregnant, breast feeding, and post partum), infants and children up to age five are eligible for WIC.

Some of the services that WIC provides at no cost to you includes, but is not limited to:

- Nutritional supplements and infant formula.
- Nutrition screening.
- Nutrition education.
- Breast feeding information.
- On-site immunization.
- Health screening for anemia.
- Health care referrals.

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You can find out more about the WIC program by calling the UHP Member Services Department at: **1-800-JOIN UHP** (1-800-564-6847). Information addressing WIC services is included in your new member enrollment package and in mailings to UHP prenatal members.

### **Head Start Medical Services**

If you are enrolling or are currently in a Head Start program, UHP will provide you with necessary medical services that Head Start says you require. These services include a physical examination, well care, and other necessary medical care and follow-up care. You may also receive necessary out-of-network services subject to UHP policy and approval. If you would like more information regarding how UHP coordinates your care with the Head Start program, you may call your PCP or the UHP Members Services Department.

### **New Member Orientations**

New member orientations take place on the 3<sup>rd</sup> Thursday of each month. You will receive a post card in the mail alerting you to time, date, and place that the orientation will be held. You may also call the UHP Outreach Department at: **1-800-508-2507** for the same information.

Topics that are discussed are, but not limited to:

- UHP history.
- Your UHP benefits.
- How to access care.
- Health education.
- Questions and answers.

### **Limitations on Services/Access to Services When Limits are Reached**

The following limitations apply to Covered Services, as indicated by the New Jersey Division of Medical Assistance and Health Services.

- Services of podiatrists shall be provided with the exception of routine foot care, and treatment of flat foot conditions, unless it is considered Medically Necessary.
- Optical appliances are limited to one (1) pair every two (2) years. No time limits apply if the recipient is younger than twenty-one (21) years of age and the appliances are Medically Necessary. University Health Plans will not pay for optical appliances which may have been lost, broken, damaged or stolen unless prior authorization is given by UHP.

### **Services Remaining In the Fee-For-Service Program that May Necessitate Assistance to the Member to Access the Services**

The following services provided by the New Jersey Medicaid program under its State plan shall remain in the fee-for-service program but may require medical orders by your PCP.

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- Outpatient Rehab – Physical therapy, occupational therapy, and speech pathology services.
  - Medical day care. (Not available for NJ FamilyCare plans B, C, and D)
  - Transportation – lower mode. (Not available for NJ FamilyCare plans B, C, and D)
  - Elective/induced abortions and related services.
  - Sex abuse examinations. Performed at DYFS contracted Child Abuse Regional Diagnostic Centers or by DYFS contracted physicians specializing in these services.
  - Services provided by New Jersey Mental Health Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings.
  - Family Planning Services and Supplies when furnished by a non-participating provider.
  - Home health agency services for non-dually eligible Aged, Blind, Disabled (ABD) population.
  - Personal care assistant services. ( Not available for NJ FamilyCare Plans B,C and D)

For more information about these services, you may call your Primary Care Provider (PCP) or the UHP Member Services Department at: 1-800-JOIN-UHP (1-800-564-6847).

### **Exclusions - Services That Are Not Covered By UHP or Medicaid**

- All services provided that are not Medically Necessary and/or not approved, or arranged by a Plan Provider are excluded, except emergency screening services.
- All infertility treatment services.
- Cosmetic surgery, except when medically necessary and approved.
- Experimental organ transplants.
- Rest cures, personal comfort, custodial care, and convenience items, services and supplies not directly related to the care of the patient including but not limited to:
  - ◆ guest meals and accommodations;
  - ◆ telephone expenses;
  - ◆ travel expenses other than those listed on page 4; and
  - ◆ take home supplies.
- All claims arising directly from services provided by or in institutions owned or operated by the federal government.
- Private duty nursing, except when appropriate for Early and Periodic Screening, Diagnosis and Treatment.
- Services provided outside the United States and territories.
- Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military.
- Blood and blood plasma for FamilyCare Plan D.

### **Health Services You Cannot Receive While You Are a University Health Plans Member**

Medicaid recipients participate in a Home and Community Based Waiver Services Program or are admitted for long term care treatment in one of the following are to be disenrolled from University Health Plans on the date of their admission to long term care. Please notify the University Health Plans Member Services Department at 1-800-JOIN-UHP (1-800-564-6847) so that a representative may assist you. When you no longer need these services you may re-enroll in University Health Plans.

- Nursing Care Facility. (Disenrollment only applies if the member is admitted for in-patient rehabilitation/post acute care services for more than 30 days.)
- Residential Treatment Care Center.

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- Psychiatric Hospital. (Does not apply to Residential Treatment Centers.)
  - Intermediate Care Facility / Mental Retardation.
  - Home and Community Based Waiver Services (Does not apply to DDD/Community Care Waiver.)

## **Services Available to University Health Plans Members Through Medicaid Directly**

### **Methadone Maintenance Treatment Services**

Methadone maintenance treatment services are not covered by University Health Plans. However, you may receive these services while a University Health Plans Member by using your Medicaid card at any Medicaid-approved Participating Provider of your choice.

### **Family Planning and Reproductive Health Services**

Family Planning and Reproductive Health Services including Plan D members are available either through the Plan or at any Medicaid approved Participating Provider of your choice. UHP members are permitted to obtain family planning services and supplies from either UHP's contracted provider network or from any other qualified Medicaid family planning provider. UHP shall cooperate with non-contracted FamilyCare providers in the coordination of care for continued medical care and the management of identified complex health care needs. If you or your

Provider have any questions concerning these services, call University Health Plans at **1-800-JOIN-UHP** (1-800-564-6847).

Family Planning and Reproductive Health Services include diagnosis, treatment, drugs, supplies and related counseling provided under the supervision of a physician for the purpose of contraception or sterilization. These services also include screening for sexually transmittable diseases.

Members may receive Family Planning and Reproductive Health Services from their University Health Plans Primary Care Provider. If your Provider has any questions about your Medicaid coverage, have him/her call University Health Plans at **1-800-JOIN-UHP** (1-800-564-6847).

Other available services through Medicaid directly include:

- Substance abuse/mental health services for non-DDD populations – diagnosis, treatment and detoxification. (NJ FamilyCare Plan D is limited to detoxification services only)
- The costs of the following medications: Risperidone, Olanzapine, Clozapine, Ziprazadone and Quetiapine, Methadone and its administration. (Not covered for NJ FamilyCare Plan D)
- In-patient and out-patient mental health services.
- Nursing facility care permanent placement. (Covered for 30 days or less for rehabilitation/post-acute care services. Member will be disenrolled from UHP on the 30<sup>th</sup> day of admission.)
- DYFS Residential Treatment Centers.
- In-patient psychiatric hospital services for individuals under 21 or over 65 years of age. Member will be disenrolled from plan on date of admission. For FamilyCare Plan D limited to 35 days per year.
- Intermediate Care Facilities/Mental Health: Covered fee-for-service and member will be disenrolled from plan on date of admission. (Plan D Members are not covered)
- Waiver and demonstration program services except clients of Division of Developmental Disabilities/Community Care Waiver. (Not covered for NJ FamilyCare Plans B, C and D)

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## How to Use University Health Plans

Your health care providers and University Health Plans are working together to provide you with quality health care coverage. There are several things that you can do to help keep yourself healthy:

1. Select one of the University Health Plans Primary Care Providers for all of your routine health care needs. If you have any questions regarding your choice of a doctor or dentist, please feel free to call one of our Member Services Representatives at **1-800-JOIN-UHP** (1-800-564-6847) to discuss your choice. In addition to treating you, the University Health Plans Primary Care Provider you choose will supervise health services performed for you by his/her assistants and nurses. You may change your PCP at any time without cause by calling the UHP Member Services Department. The change will be effective on the first of the month following the month you made the requested change. For example, change requests made in October will be effective on the 1<sup>st</sup> of November.
2. Make appointments for routine physicals and dental examinations for all eligible family members as soon as possible after your UHP membership becomes effective. Adults are encouraged to have their appointment for a physical exam within 180 days from their effective date of enrollment. Children are encouraged to have their appointment for a physical exam within 90 days from their effective date of enrollment.
3. Visit your University Health Plans Primary Care Provider regularly, not only when you are sick. Regular checkups help prevent and detect the start of serious medical problems. The better your PCP knows your health, the more he/she can help you.
4. After you or a family member receives emergency treatment at any hospital or emergency room, schedule a follow-up appointment with your PCP as soon as possible so that he/she can follow your recovery.
5. Use your University Health Plans PCP for all your medical needs. Except for emergencies and authorized referrals, you may not be covered if you go to another doctor, health center or hospital. You will be covered for services by out-of-network specialists if none are available in the plan and your treatment is medically necessary.
6. If the plan does not receive your PCP selection after 10 days of your effective date, a PCP will be assigned to you and a UHP ID card will be mailed to you within 15 days after the effective date of enrollment. You will be assigned a PCP who speaks your primary language, if available. However, if you have a prior relationship with a PCP already in the plan, that PCP will be assigned to you first. The proximity of the PCP to your home is also taken into consideration.
7. A PCP may request reassignment of an enrollee for irreconcilable differences, when an enrollee has taken legal action against the provider, or if an enrollee fails to comply with health care instructions and such non-compliance prevents the provider from safely and/or ethically proceeding with that enrollee's health care services. Reassignment may be communicated to the enrollee by the PCP or the Plan on behalf of the PCP.
8. UHP Primary Care Providers are encouraged to contact each new enrollee to schedule an appointment for a complete age/sex specific base line physical exam.

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## Accessing Care

Your University Health Plans Primary Care Provider (PCP) will provide or arrange for any medical services that you need, including:

- Complete physical exam
- Laboratory tests or x-rays
- Specialist referrals
- In-patient or out-patient hospital care
- Urgent care (urgent but non-life threatening care)
- Two wellness visits per year through a member's OB/GYN without the need for PCP referral.

Please call your Primary Care Provider as soon as possible to make an appointment. This will allow your provider to become familiar with you and evaluate your health. Then, when you call your PCP about an illness, he/she will already be familiar with you. If you have any questions regarding your health, call your PCP. Your PCP may employ other health care practitioners who may participate in your care.

To arrange for dental services, call the office number of the UHP participating dentist you have chosen and make an appointment. Be sure to have your University Health Plans ID card ready.

We encourage all members to make appointments as soon as possible for preventive health check-ups with your PCP and preventive dental check-ups with participating UHP dentists.

### **If You Incorrectly Receive a Bill for Services**

If you receive a bill from a Provider or for an out-of-network service which you feel is not your responsibility to pay, you may send the bill to: University Health Plans, Inc., PO Box 7949, Lake Forest, IL 60045. Be sure to include in your correspondence your UHP ID card number and the reason you feel you were billed incorrectly.

**Please note: Members who self-refer for non-authorized services in-network or out-of-network may be held financially responsible for such services. Members who receive Non-covered services may be held financially responsible for such services, or who fail to comply with HMO regulations and services may be held financially responsible for such services. Providers should inform members prior to treatment for any services that are not covered for which the member may be billed.**

### **Members With Special Needs/Care Management Program**

University Health Plans will make all reasonable efforts to ensure members who have special needs that they will have access and quality of care as is provided to all other members.

Members with special needs may be defined as, but not limited to, the following:

Adults who have a complex/chronic medical condition requiring specialized health care services, including persons with physical, mental, substance abuse, and/or developmental disabilities, including such persons who may be homeless.

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Children with special health care needs are those who have, or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children in general.

Care Management programs for the members described above shall include, but are not limited to:

- Pregnancy services.
- EPSDT.
- Mental health and substance abuse coordination.
- HIV/AIDS services coordination.
- Dental services for enrollees with developmental disabilities.
- Asthma and diabetes, in adults and children.

Members in need of complex needs assessment shall be identified as follows:

- Identified on the enrollment application
- A Member or authorized person requests an assessment
- The Member's primary care provider requests an assessment
- A state agency involved with a Member's care requests an assessment and
- A Member's status otherwise indicates.

UHP shall use the following as indicators for Complex Needs Assessment:

- Poor health or functional status (as reported by the Member or authorized person) including children with some degree of delay or disability, and members of the DDD
- Existing Care Plan/Care Manager
- Request for an assessment from the Member or authorized person
- Request for an assessment from a state agency or private agency contracting with DDD involved with the Member
- Chronic condition
- Recent hospitalization or admission to a nursing facility
- Recent critical event such as the death or relocation of a family Member or move to a new home
- Existence of multiple medical or social service providers in the life of the Member
- Use of prescription drugs, particularly multiple drugs
- Use of interpreter or any special services and
- Members who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office or elsewhere when such behaviors may relate to or result from the existence of the Member's special needs including developmental disabilities.

UHP will respond to all requests for assessments received from network providers, state agencies, private agencies under contract with DDD, self referrals or when applicable from an authorized person within ten business days of receipt of the request.

All Complex Needs Assessments will be completed within thirty days of receipt of request or identification of need for assessment/reassessment.

Upon identification of the enrollee's special needs identified through a complex needs assessment, an Individual Health Care Plan (IHCP) timeline will be developed within 90 days of the effective date of the

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enrollment for children under the age of 21 and for adult clients of DDD, and within 180 days after initial enrollments for adults. All enrollees are encouraged to contact their PCP or UHP to schedule an appointment.

### **Coordination of Care**

UHP shall honor plans of care for newly enrolled Members, including prescriptions, durable medical equipment, medical supplies, prosthetic and orthotic appliances, and any other on-going services initiated prior to enrollment with UHP.

Services shall be continued and authorized by UHP's Medical Management Department until the Member is evaluated by his/her UHP Primary Care Provider and a new plan of care is established.

### **Notification of Lab and X-Ray Results**

**Normal results** of routine laboratory and/or radiology (x-ray) testing shall be delivered to all members within 10 days of the provider's receipt of said results.

**Urgent** abnormal results shall be communicated to the member (responsible party) within 24 hours of the provider's receipt of said results. This can be accomplished by telephone, or written correspondence from the provider's office.

### **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

UHP will provide the following preventive, medical and dental EPSDT services to members. These services include, but are not limited to:

- A comprehensive health and developmental history including assessments of both physical and mental health development.
- A comprehensive physical examination including vision and hearing screening, lead screening, dental inspection and nutritional assessment.
- Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practices for pediatric vaccines.
- Health education/anticipatory guidance.
- Referrals for further diagnosis and treatment or follow-up of all abnormalities.

EPSDT information is initially sent to eligible members upon enrollment with UHP. Eligible members are also notified by mail quarterly, advising them to obtain the required appointment with their PCP. Members are encouraged to utilize this very important program.

### **Coverage if You Are Out of the UHP Service Area**

UHP shall authorize coverage of contracted benefits for Members out of the area in the following cases:

- In emergency situations;

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- For non-emergencies when travel back to service is not possible;
  - In situations where required service is not available within the UHP service area.

UHP shall not be held responsible to authorize services for members out of the area in the following scenarios:

- Members residing out of the UHP service area for more than thirty (30) days (routine care only).
- UHP shall not be responsible for health care benefits for full-time students who are attending school and residing out of the country while that Member is in school.

Emergency services do not require a referral. If you seek out-of-area emergency services, notify UHP within 48 hours or as soon as possible. You may have someone call for you if you cannot.

### **Access to Mental Health and Substance Abuse Services**

Mental Health/Substance Abuse cases will be managed by the State's Fee-for-Service Medicaid Program for all non-DDD members. Services covered by the Medicaid Fee-for-Service Program includes substance abuse services, including diagnosis, treatment and detoxification, costs for methadone and its administration, and mental health services. UHP PCP's and other providers shall initiate the screening process at the earliest possible time after the on-set of a condition that may require mental health substance abuse treatment. All required services will be provided by the Member's PCP except in those cases where services are not covered by UHP.

All FDA approved psychotropic medications (excludes Clozapine, Risperidone, Olanzapine, Quetiapine and Zipradone) are provided through the Merck-Medco PAID program and do not require prior authorization.

Members are entitled to 30 days of in-patient benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse or addiction and non-biologically based mental illnesses.

Court ordered chemical dependency admissions are not covered unless medically necessary and appropriate.

### **Alcohol Abuse and Biologically Based Mental Illness**

If treatment is indicated, a referral from the member's primary care physician to a participating provider is required. All elective hospitalizations require prior authorization from University Health Plans Medical Management Department.

### **Importance of Informing University Health Plans of Address and Telephone Number Changes**

It is very important that you call a University Health Plans Member Services Representative at **1-800-JOIN-UHP** (1-800-564-6847) any time your address or telephone number changes.

You may also write to University Health Plans at: 550 Broad Street, 17<sup>th</sup> Floor, Newark, NJ 07102.

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This will allow you to receive important information from University Health Plans regarding new services that we may offer.

This will also help your University Health Plans PCP to maintain contact with you concerning your health and the health of your enrolled family Members.

In addition, please notify University Health Plans if your Medicaid number or medical assistance category changes.

## **How to Use the University Health Plans Card and Medicaid Card**

Each individual Member enrolled in University Health Plans will receive a plastic University Health Plans ID card. Please use the University Health Plans card and Medicaid card as follows:

Show your University Health Plans card and Medicaid card to receive prescriptions at any participating “PAID Prescriptions (Merck-Medco)” pharmacy. A list of participating pharmacies is included in your new member packet.

Show your University Health Plans card and Medicaid card to receive health services at your University Health Plans Primary Care Provider’s office, dentist’s office or at the office of a health care provider authorized by your Primary Care Provider or University Health Plans.

Do not throw away your Medicaid card! Show your Medicaid card to receive methadone Maintenance Treatment, certain Mental Health and Substance Abuse Services and Family Planning Services outside the

University Health Plans provider network. Also show your Medicaid card to receive these services: induced/elective abortions, livery transportation, personal care assistants and medical day care services. If you are not sure how and where to receive these or any other services, call our Member Services Representatives at **1-800-JOIN UHP** (1-800-564-6847) and we will help you. Additional information about how to access these services is found on page 7 of this handbook.

If you lose your University Health Plans card, or if any information on the card is not correct, please call the University Health Plans office immediately at **1-800-JOIN UHP** (1-800-564-6847) so we can issue you a new card.

## **Making Appointments**

To make a medical appointment, call your University Health Plans Primary Care Provider’s office at the number listed on your ID card. You should have the following information on hand to give to the appointment clerk:

- Patient’s Name;
- Doctor’s Name;
- University Health Plans ID Number; and

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- Reason for the Appointment.

We encourage you to make an appointment with your PCP as soon as possible.

### **Canceling Appointments**

If you cannot keep a scheduled appointment, please call as soon as possible to cancel the appointment. Please call your doctor's office as soon as you know you will be unable to keep the appointment so the appointment can be rescheduled for you. If you have difficulty getting to your appointment, call a University Health Plans Member Services Representative at **1-800-JOIN-UHP** (1-800-564-6847) so that they may assist you in arranging transportation. Please call as soon as you know that you require transportation.

### **Referrals for Specialty Services**

All referrals for specialty medical services must be made by your University Health Plans Primary Care Provider. Members may be referred to an out-of-network Provider when none is available in-network to meet the health care needs of the enrollee. These appointments are very important, so please go to all of your specialist appointments. When you go to a specialist, remember to take with you your University Health Plans ID card and Medicaid card along with the referral form your Primary Care Provider gives you.

No referral is required for routine eye care or routine dental work. Routine eye care is periodic inspection of your eyes by your family physician plus an eye chart test. Routine dental care is an examination of your mouth, teeth, and gums by your participating dentist.

If you suspect that you are HIV positive or suspect that you may have AIDS, you may self-refer yourself to the Department of Health by calling their hotline number at: 1-800-624-2377. At no cost to you, the Department of Health will tell you when and where to go to have necessary lab tests, and all information regarding the above will be totally confidential.

With the exception of life-threatening emergencies, UHP Primary Care Physicians will generate any and all referrals, including verbal or written requests from members for specialty services and submit them to UHP for authorization. Referrals are needed for specialty providers, laboratory and x-ray services, and other diagnostic procedures. All referrals are valid for a period of 90 days and will allow for the rescheduling of specialist appointments. An exception to this policy allows female members the opportunity to schedule 2 well women exams yearly without obtaining a referral from their PCP. GYN problem visits require referrals.

Referrals are not needed for preventive dental care and routine vision care visits to participating UHP providers. However, referrals to dental specialists will be generated by the primary dental provider. Members in need of on-going specialist care are not required to obtain referrals from their PCP to continue receiving the routine specialty care.

The following is information you should know:

- Referrals are obtained from the PCP following his examination and/or evaluation of the medical/surgical problem.
- The referral will be processed within 2 working days of the request or one day in urgent cases. Authorizations are provided telephonically in urgent situations.

- You are to present the written referral to the specialist upon arrival at his/her office.
- Members with difficulties traveling to obtain a paper copy of the referral should request the faxing of said referral by their PCP to the specialist's office.
- For standing referrals (a standing referral is authorization of more than one visit to a specialist without returning to your PCP for another referral to the same specialist), the plan will authorize and document in the system, the specialist seen, the care required and the frequency of visits.

## **Emergency Medical Services**

### **Non-Emergency Conditions That Are Urgent**

An urgent condition is one that requires medical treatment within 12 hours. An emergency requires immediate care. In the case of a non-emergency, follow these steps:

- Call your University Health Plans Primary Care Provider's office. The name and phone number are on your UHP ID card. You may be given advice over the phone, told to come in that day or told to go to a hospital emergency room.
- If your University Health Plans Primary Care Provider's office is closed, call the University Health Plans twenty-four (24) hour hotline at **1-800-JOIN-UHP** (1-800-564-6847) if you are in New Jersey or 1-973-623-8700 if you are outside New Jersey.
- Be prepared to tell the University Health Plans operator about your health problem. Also, know your University Health Plans and Medicaid ID numbers, as well as a phone number where you can be reached.
- The operator will assist you in contacting your UHP Primary Care Provider. The Provider may need to call you back, so please keep your telephone line free.
- Your Primary Care Provider will ask you about your illness and will determine the best course of treatment.
- Routine eye care and routine dental care is not a true emergency or life threatening. Some examples of life threatening emergencies are: chest pain, poisoning, uncontrolled bleeding.
- If you are outside the UHP service area, you will be instructed where to go. If you are in New Jersey, you may be told to obtain service from a physician or hospital with whom your Provider has a professional relationship. If you are traveling outside of New Jersey, it is likely that you will be asked to obtain services from a local provider or from the nearest Emergency Room.
- Just like you do at your own doctor's office, you must bring your University Health Plans ID card and Medicaid card with you to receive treatment. Ask the doctor's office to call your University Health Plans Primary Care Provider or University Health Plans as soon as possible.

These conditions are generally **NOT** considered to be an emergency:

Bumps and Bruises	Pinkeye	Coughs	Vomiting
Minor Lacerations	Swollen Glands	Diarrhea	Rashes
Sprains and Strains	Cramps	Fatigue	Poison Ivy
Earaches	Colds, Sore Throats		

These conditions listed below are generally considered to reasonably substantiate that an emergent/urgent medical condition exists:

- Severe pain of any kind.

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- Altered mental status, sustained or transient, for any reason.
  - Abrupt change in neurological status, sustained or transient, for any reason.
  - Complications of pregnancy.
  - Chest pain.
  - Acute allergic reactions.
  - Shortness of breath.
  - Abdominal pain.
  - Multiple episodes of vomiting or diarrhea, any age.
  - Fever greater than 102.5°F in any age group.
  - Fever greater than 100.4°F in infants three months or younger.
  - Injuries with active bleeding.
  - Injuries with functional loss of any body part.
  - All patients arriving at the hospital by ambulance after an injury with any body part immobilized.
  - All patients arriving at the hospital by paramedic ambulance.
  - Symptoms of substance abuse.
  - Psychiatric disturbances.

UHP will pay for a medical screening exam in an emergency room to determine whether an emergency exists.

### **Dental Services**

Preventive, prophylactics, diagnostic major and minor restorative, endodontic, surgical, and adjunctive services, orthodontia and periodontal services and prosthodontia are covered.

### **Emergency Dental Services**

All UHP Members have the right to obtain emergency dental services within the following limits: **Emergency care: immediately or within 24 hours. Routine appointments within 2 weeks.**

Network dental providers must be available by telephone 24 hours a day, 7 days a week or must have arrangements for telephone coverage by another UHP participating dentist or advise the member to call the plan for referral advice to a network dentist.

Members requiring emergency dental care when out of state, call Member Services at **1-800-564-6847** to receive assistance in accessing care or may access any licensed provider without the need for prior authorization. Please call UHP within 48 hours if you have obtained emergency dental services out of state. Someone may call for you if you cannot.

For Plans A, B, and C, there is no cost sharing for Dental Services.

### **Life-Threatening Emergencies**

**If you have a life-threatening emergency:**

Go to the nearest emergency room or call 911. You do not need prior authorization to obtain emergency services in or out of network. Medical emergency services shall include a medical screening, admission to the hospital if necessary and coordination of any follow-up care with the members Primary Care Physician (PCP) or Specialist.

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If possible, bring your University Health Plans ID card and your Medicaid card and present it to receive treatment. You or the health care provider must notify University Health Plans of your visit to the emergency room within forty-eight (48) hours or as soon as possible. The best time to call is during regular business hours.

### **What is a Life-Threatening Emergency/Emergency Medical Condition?**

A prudent lay person may define an emergency medical condition as one in which an individual who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The following conditions may be considered  
LIFE THREATENING EMERGENCIES:

- Chest Pain
- Poisoning
- Uncontrolled Bleeding
- Loss of Consciousness
- Severe Shortness of Breath
- Suspected Overdose of Medication

***YOU DO NOT NEED TO CALL UNIVERSITY HEALTH PLANS BEFORE RECEIVING TREATMENT FOR A LIFE-THREATENING EMERGENCY.***

## **How to Get Your Prescription Filled**

Medications prescribed by your University Health Plans Primary Care Provider may be filled at any University Health Plans affiliated pharmacy. Look for the "PAID Prescriptions (Merck-Medco)" indicator on the pharmacy's door. You will need to present your University Health Plans ID card and Medicaid card to the pharmacist in order to receive the prescription without cost to you. For a listing of PAID Prescriptions/University Health Plans pharmacies, consult your membership packet or call PAID Prescriptions Member Services at **1-800-988-4124**. You may also call UHP Member Services at **1-800-JOIN-UHP** (1-800-564-6847). If you have a problem with the pharmacist recognizing your ID Card, please call us from the pharmacy so we can fix the problem while you are at the pharmacy. This will allow you to receive your prescription while you are at the pharmacy. **Do not go to a Non-PAID Prescription Pharmacy, because they will NOT fill your prescription.**

Should UHP determine that a member's use of the pharmacy service has been abnormal, the member may be restricted to using one pharmacy of their choice within the pharmacy network. If the choice has been restricted and a medical emergency arises, and the pharmacy to which you are restricted cannot serve you, you may obtain a seventy-two (72) hour supply of the necessary prescription at another pharmacy. These "lock-in" provisions do not apply to SSI and NJ FamilyCare A, B, D individuals. Clients of DDD or individuals eligible through DYFS.

## **Transportation**

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Please call the UHP office if you cannot travel for routine appointments because of a chronic illness or condition. If an invalid coach or ambulance service is ordered and approved by University Health Plans, University Health Plans will make the arrangements and cover the costs.

If you require lower mode or routine transportation service, you may also call University Health Plans' Member Services Department at **1-800-JOIN-UHP**, (1-800-564-6847). A representative will supply you with the names and phone numbers of the Medicaid approved transportation providers. Please contact the County Welfare Agency (CWA) office to get routine or lower mode transportation. For Essex or Hudson County, call the Medical Assistance Customer Center (MACC).

If you are home bound and there exists a medical condition that requires additional assistance, please contact a Member Services Representative. In a life-threatening emergency, you do not need prior authorization. For emergency transportation, DIAL 911.

### **Pregnancy Care and Newborn Children**

As soon as you think you are pregnant, please notify your University Health Plans Primary Care Provider and a University Health Plans Member Services Representative. This will help us to arrange for your prenatal appointments and give your baby a healthy start in life.

Newborn children in your family should be enrolled in University Health Plans. To do this, report the birth of your child to your County Welfare Agency. They will add your child to the eligibility file and UHP will take the necessary steps needed to enroll your child. If necessary, they will direct you to an appropriate County Welfare Office.

Please contact a UHP Member Services Representative at **1-800-JOIN-UHP** (1-800-564-6847) in order to choose a PCP for your baby.

### **For the Hearing, Speech, and Visually Impaired**

UHP Member Services representatives can assist hearing impaired or speech impaired members, if needed, by using one of the A T & T, TTYD services. There are three (3) telephone numbers available for use by members:

1-800-852-7897 for voice users, 1-800-852-7899 for telecommunications relay services, and 1-800-855-2881 for general use. Audio tapes are available for the visually impaired.

### **Translation Services**

UHP has contracted to provide you with a translation service so that you may communicate with us in your primary language on the telephone. Tell the UHP operator the language that you need and an interpreter will be provided.

### **The University Health Plans Member Services Representative**

The Member Services Representative is a staff person who knows how the University Health Plans system works. Our Member Services Representatives will help you with any questions or problems that you may have

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concerning your health care coverage. We have representatives who speak many languages. They can also help you to select a Primary Care Physician (PCP) if necessary.

Call the Member Services Representative at **1-800-JOIN-UHP** (1-800-564-6847) Monday through Friday from 9:00 a.m. to 5:00 p.m. if you have any questions or problems. (S)he can:

- Help you by explaining the Plan.
- Help you solve any problem you may have with the Plan.
- Help you with medical emergency situations.

After 5:00 p.m. and on weekends, UHP's phone will be answered by a medical answering service. If your call requires a doctor's advice, please call your Primary Care Provider's office. If you don't know the name of your Primary Care Provider, or need their phone number, the operator will assist you. If your call is for non-medical reasons, you will most likely be told to call back during regular business hours.

### **Medicaid Benefits Received After Age 55**

Medicaid benefits received after age 55 may be reimbursable to the State of New Jersey from the enrollee's estate. The recovery may include premium payments made on behalf of the beneficiary to the managed care organization in which the beneficiary enrolls.

### **Disenrollment and Grievance Procedures**

We hope you will be completely satisfied with University Health Plans. However, if any problem(s) arise, please call a University Health Plans Member Services Representative at **1-800-JOIN-UHP** (1-800-564-6847). We will try to help. If you remain dissatisfied, you may file a formal grievance and/or disenroll from the Plan. You have the right to identify your reasons for disenrolling in writing. If you voluntarily disenroll, you should return your UHP ID card to the plan.

### **Grievance**

**If you want to file a formal grievance, you may:**

Call the University Health Plans Member Services Representative to schedule an appointment at University Health Plans. The Member Services Representative will explain the grievance process and help you fill out the grievance form.

Your grievance will be noted and forwarded to the Chief Operating Officer of the Plan. You will receive a written confirmation within ten (10) working days that your grievance is under investigation. Formal grievances regarding urgent care must be resolved within 48 hours.

If the grievance is not resolved within twenty-five (25) days, it will be taken to the Grievance Committee of the University Health Plans Board for final resolution. The Committee, held when necessary, will include one member of the University Health Plans Board, a representative from one of our contracted health providers and at least one University Health Plans enrollee. If you are not happy with the result of your grievance, you may request a Medicaid Fair Hearing and/or also contact the New Jersey Department of Health and Senior Services and/or the New Jersey Department of Banking and Insurance (refer to 'Utilization Appeals Procedures' below).

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NJ FamilyCare Plan A members have the right to a Medicaid Fair Hearing (except for NJ FamilyCare Plans B, C and D Members) if your complaint cannot be resolved within forty-five (45) days and all efforts by UHP to resolve your complaint to your satisfaction have been exhausted. You must apply for a Medicaid Fair Hearing within ninety (90) days of filing the grievance. To arrange a Medicaid Fair Hearing, write to the following address:

**Division of Medical Assistance and Health Services  
Medicaid Fair Hearing Section  
P. O. Box 712  
Trenton, NJ 08625-0712**

You have the right to have your grievance and appeal decisions communicated to you in your primary language.

### **Utilization Appeals Procedure**

A UHP Member and/or a provider, acting on behalf of the Member with the Member's written consent, may appeal any utilization management determination resulting in a denial, termination or other limitation of covered health care services. Members have the right to have denial or appeal decisions in their primary language.

#### **Stage One (1) Informal Internal Process**

- Upon receipt of the determination, the Member and/or provider, with the Member's written consent, may initiate a Stage One (1) appeal within thirty-one (31) days.
- The Member and/or provider can initiate an appeal verbally or in writing.
- The Member and/or provider shall have the opportunity to discuss and appeal the determination with the UHP Medical Director, or his/her designee, who rendered the determination.
- All "appeals" involving urgent care shall be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event shall exceed seventy-two (72) hours for urgent appeals and immediately for emergency appeals. In all other cases, appeals shall be concluded within five (5) business days from the date that we receive the appeal.
- Members and/or the providers will be notified of the determination in writing and will include the criteria upon which the determination is based along with instructions for proceeding to the next level of internal appeal.

#### **Stage Two (2) Formal Internal Appeal**

- A UHP Member and/or provider acting on behalf of the member with the member's consent can initiate a Stage Two (2) appeal verbally or in writing.
- A UHP Member and/or provider has a minimum of thirty-one (31) days from receipt of the denial to file an appeal.

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- UHP shall maintain specialty appropriate appeals / grievance committees comprised of health care professionals distinct from the group involved in the initial Utilization Management determination.
  - All Stage 2 appeals must be sent to the UHP's Medical Director.
  - At the request of the Member and/or provider, a consulting practitioner or professional who was not involved in the determination may participate in the Stage 2 appeals process.
  - UHP will conclude all emergency and urgent appeals within seventy-two (72) hours from the date of the request and will conclude all other appeals within twenty (20) days.
  - UHP may make a request of the Department of Health and Senior Services' Office of Managed Care for an extension of twenty (20) additional business days to review utilization appeals.
  - UHP shall provide the Member and/or a provider with written notification of decision and, if a denial, the reasons together with a written notification of the Member's right to proceed to an external (Stage 3) appeal.

### **Stage Three (3) External Appeal**

- The UHP Member and/or a provider on behalf of the Member with the Member's consent may file an external appeal by submitting a completed Independent Utilization Review Organization (IURO) form and the appropriate fee to the Office of Managed Care (OMC). The decision of the IURO shall be binding upon UHP and the Member. Written notification shall be provided to UHP and the Member.
- The fee for filing an appeal is \$25.00, payable by check or money order to the New Jersey Department of Health and Senior Services. Upon determination of financial hardship, the fee may be reduced to \$2.00.
- The Member and/or the provider has sixty (60) days from receipt of the denial to initiate a State 3 appeal.
- The appeal should be mailed to:

**Department of Health and Senior Services  
Office of Managed Care  
Division of Health Care System Analysis  
P. O. Box 360  
Trenton, New Jersey 08625-0360**

### **Disenrollment**

If you want to disenroll, you may go to an authorized New Jersey Care 2000+ Health Benefits Coordinator to fill out a disenrollment form or call toll free 1-800-701-0720 (TTYD). You may disenroll without cause from UHP within the first ninety (90) days of your date of enrollment or date you received notice of enrollment, whichever is later. Plan A Members are required to join another health plan, you may not disenroll to fee-for-service. After the 90-day period, you cannot disenroll without good cause until 12 months after the initial date of your enrollment. For good cause, you can disenroll at any time.

Although you are not required to answer any questions, inquiries may be directed to you so that we may improve our services to Plan Members. Enrollment and disenrollment is subject to verification and approval by DMAHS.

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It will take thirty (30) to forty-five (45) days for your disenrollment to become effective.

SSI, New Jersey Care 2000+, Special Medicaid Program, Aged, Blind and Disabled, DDD members and members eligible through the Division of Youth and Family Services (DYFS) may disenroll at any time.

UHP will assist and/or facilitate the transfer of all medical records (with your consent and only after you voluntarily sign a release form) to the new provider, the enrollee or enrollee designate, an adoptive parent or a representative of DYFS, once the request for a transfer has been approved.

## **Conditions Causing Your Coverage in University Health Plans to Terminate**

- You voluntarily disenroll from the plan.
- You are no longer eligible for Medicaid.
- You act fraudulently or improperly as a Member of University Health Plans.
- You move out of the Plan's service area (ABD, DDD, and DDD/CCW non-duals will not forfeit UHP membership if you move out of the county or service area).
- If you voluntarily disenroll from the plan, please return your UHP ID card to: University Health Plans, Inc., 550 Broad Street, 17<sup>th</sup> Floor, Newark, NJ 07102, Attn: Member Services. – If you disenroll voluntarily, you may identify the reason in writing and inform the plan.

If you are disenrolled for alleged fraud or improper behavior, you have a right to a Medicaid Fair Hearing. To arrange a Fair Hearing, write to the following address:

**Division of Medical Assistance and Health Services  
Medicaid Fair Hearing Section  
P. O. Box 712  
Trenton, NJ 08625-0712**

## **The Rights of University Health Plans Members**

### **Members have a right to:**

- Receive high quality health care from caring, responsible and competent health care providers.
- Receive health care services regardless of age, race, sex, creed, color, religion, nationality or sexual orientation.
- Have their medical problems and treatment options explained fully and clearly so that they will be able to give an informed consent to the treatments and/or procedures suggested by their health care provider.
- You have the right, upon request, to receive a copy of your medical records.
- Consent to releasing your medical records only after you voluntarily sign a release form.
- Refuse treatment, to the extent permitted by law, and be clearly informed of the medical consequences of your refusal.
- Ask questions and receive up-to-date information regarding their health, health problems and medical treatment(s) from your health care providers.

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- 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.
  - Confidentiality with respect to their medical records, except as required by law or contract.
  - Participate in decision-making regarding your health care, including second opinions, please see your PCP.
  - Provide for “Advance Directives” or “Living Wills” so that your wishes regarding your health care are known if you are unable to make decisions about your care.
  - Disenroll from the plan at any time with cause.
  - Have your concerns, suggestions or complaints registered with a Member Services Representative, and have them acknowledged in writing within fifteen days.
  - File a formal grievance.
  - To receive a summary of survey results if applicable.
  - Information regarding Stop-Loss information.
  - To 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.
  - The health status survey (obtained only by the HBC) completed on your application will be communicated to your health care contractor by the Health Benefits Coordinator.
  - Be treated with respect and dignity.
  - Receive information regarding this health plan.
  - Receive care in a hospital for at least forty-eight (48) hours after delivering a child vaginally, or at least ninety-six (96) hours after a caesarean section delivery.
  - Have the right to obtain a second opinion.
  - Obtain a current provider directory.
  - Make suggestions for changes to policies and procedures.
  - Have a choice of specialists and a description of the referral process for specialty and ancillary care and second opinions.
  - Obtain a standing referral and 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 the plan.
  - To be free from balance billing.
  - To contact DHSS, DOBI, DHS, if dissatisfied with the plan’s resolution to a complaint.
  - Have the plan pay for a medical screening exam in the emergency room to determine whether an emergency exists.
  - Receive up to 120 days of coverage, if medically necessary, from a doctor who has been terminated from UHP.
  - Have doctors discuss all medical treatment options, even if they are not a covered service.
  - Know how UHP pays its doctors, including whether or not UHP uses a physician incentive plan (PIP) that effects 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 the plan and then through an independent organization for a filing fee. Have appeal and grievance decisions communicated to you in your primary language. The right to have a medicaid fair hearing.
  - Neither the member or the doctor may be penalized for filing a complaint or appeal.
  - ABD enrollees have the right to disenroll from the plan at any time.
  - Have the right to make decisions about their health care based upon physical, cultural, linguistic and religious beliefs.

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- Change your Primary Care Physician without cause by contacting UHP Member Services at 1-800-564-6847. You may be asked to select another PCP if the physician you want to select has a closed panel.

## **Rights of Minors**

For any individual under 18 years of age, his/her parent or legal guardian must first approve the health care services that individual receives. However, minors have the right, under certain conditions and as permitted by law, to receive health care treatment without the approval of their parent or legal guardian. For example, pregnant teenagers may receive treatment without first obtaining parental/guardian approval. In an emergency when approval cannot be obtained, emergency services may be provided.

In addition to the above rights, we provide to our enrolled members the following:

- New Member orientation.
- Attendees may receive additional information and incentives.

## **The Responsibilities of University Health Plans Members**

- Notify UHP or the Health Benefits Coordinator at 1-800-701-0720 (TTYD) of all your physician/patient relationships that existed prior to your enrollment with UHP.
- Make an appointment to see a University Health Plans Primary Care Provider (PCP) immediately after joining.
- Visit their Primary Care Provider regularly, not only when sick, and follow his/her advice. Keep the PCP fully informed after receiving hospital or emergency room services. Your PCP may request that you be reassigned to a different PCP if you do not follow his/her medical advice or instructions, act abusively, or have taken legal action against the provider.
- Keep appointments.
- Treatment of minors must be approved by a parent or legal guardian.
- Use the hospital emergency room only for life-threatening emergencies.
- Go to the University Health Plans Primary Care Provider for all their health care needs.
- Call a University Health Plans Member Services Representative with any questions about how to use the services covered under the Plan.
- Notify University Health Plans with any changes in aid status, dependents, employment, address or telephone number. Please note that moving outside of the plan's service area may require disenrollment in the plan.
- Return the University Health Plans PAID Prescriptions/University Health Plans card on the date coverage terminates.
- To comply with HMO regulations and policies, failure may result in billing for services.
- Your signature on the application form authorizes the lawful release of medical history and health care records for you and your applicable family members to any person(s) who shall provide health care to you as long as you are members of this plan.
- To keep track of cost sharing amounts paid, and to notify UHP Member Services if cost sharing amounts are exceeded.

## **Advance Directives**

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You have the right to make decisions related to your health care, as a Member of University Health Plans, Inc. This right includes the right to decide ahead of time how you want to be treated in the event that you are physically or mentally unable to decide for yourself in the future. This is commonly referred to as the right to give an "advance directive." An advance directive is a document that allows you to direct who will make health care decisions for yourself in the future. Your advance directive can be used to request or refuse a procedure or treatment, including life support treatment.

There are three (3) types of advance directives that you can use. They are listed and described below:

***Instruction Directive*** (also called a "living will"): lets you state what kinds of medical treatments you would request or refuse in certain situations;

***Proxy Directive*** (also called a "durable power of attorney for health care"): lets you name a "Health Care Representative," such as a family member or friend, who shall make health care decisions on your behalf should you be unable to make those decisions for yourself; and

***Combined Directive***: lets you name a Health Care Representative, who shall be bound by your instructions regarding treatment.

Your provider should discuss advance directives with you. If you are eighteen (18) years of age or older, you may fill out an advance directive on your own. If you decide to complete an advance directive you should discuss it with your provider, give a copy of the directive to your provider and another copy to your Health Care Representative, family member(s) or others close to you. Also make sure that you take a copy with you when you must receive care at hospitals or other health care facilities. Everyone responsible for your care must respect your wishes that you have stated in your advance directive.

If you change your mind regarding your advance directive, you can: select a different Health Care Representative; change your treatment instructions; or revoke the advance directive altogether.

If you have questions or need assistance completing an advance directive, speak with your provider or contact UHP's Member Services Department at 1-800-JOIN UHP (1-800-564-6847).

## **Summary of Important Facts You Need to Know About University Health Plans**

Important things to do immediately after enrolling in University Health Plans:

- Read this handbook and keep it available for use;
- Make appointments for routine physicals for all enrolled family members on the first available date; and
- Call the University Health Plans Member Services Representative if you have any comments or questions.

**If you have a LIFE THREATENING EMERGENCY, go to the nearest emergency room or call 911.**

Call the University Health Plans toll-free number at **1-800-JOIN-UHP** (1-800-564-6847):

- **Twenty-four (24) hours a day, seven (7) days a week if you have a NON-LIFE THREATENING EMERGENCY, or need medical attention and you cannot reach your University Health Plans Primary Care Provider's office.**

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- Monday-Friday from 9 a.m. to 5 p.m. if you have any questions on how to use the Plan. Ask for the Member Services Representative.
  - After 5:00 p.m., on holidays and on weekends, UHP's phone will be answered by a medical answering service. If your call requires a doctor's advice, please call your Primary Care Provider. If you don't know the name of your PCP or need their telephone number, the operator will assist you. If your call is for non-medical reasons, you will most likely be told to call back during regular business hours.

Also:

- Visit your University Health Plans Primary Care Provider for health maintenance and not just when you're sick. **Remember, you will usually need an appointment.**
- If you cannot keep a scheduled appointment, call to cancel as soon as you know that you cannot keep the appointment.
- Bring your University Health Plans ID card and Medicaid card whenever you go for health care services or prescriptions. You must present your card to receive services or prescriptions.
- Notify University Health Plans anytime your address or telephone number changes.
- You may write to University Health Plans at: 550 Broad Street, 17<sup>th</sup> Floor, Newark, NJ 07102.
- If your University Health Plans Primary Care Provider or dentist has any questions about your University Health Plans health insurance, have them call University Health Plans at:  
**1-800-JOIN-UHP (1-800-564-6847).**

*Welcome  
to  
University Health Plans!*

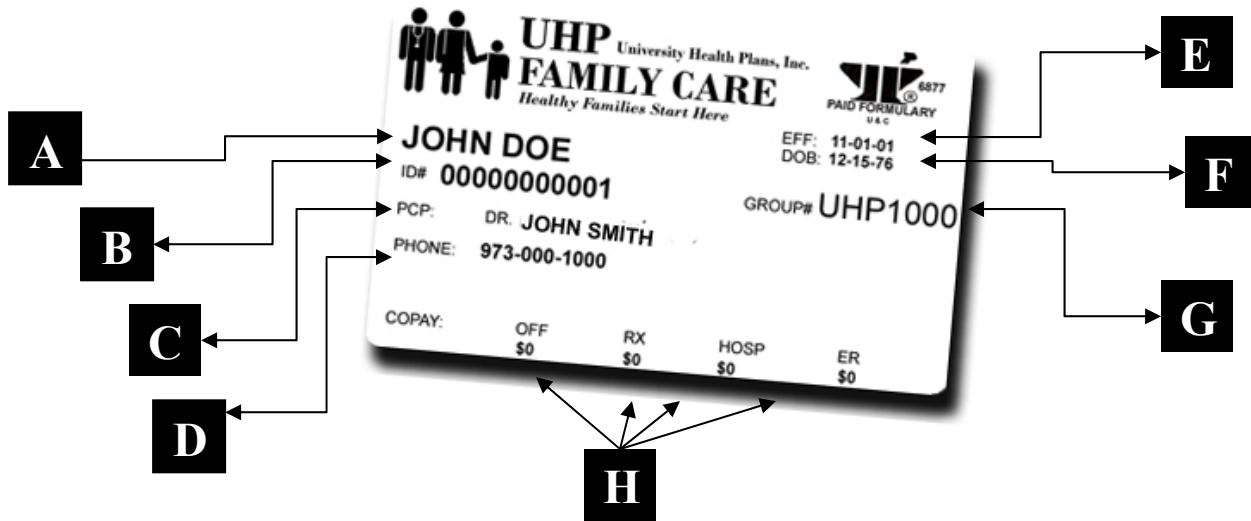
Coverage Description	NJ FamilyCare A	NJ FamilyCare B	NJ FamilyCare C	Coverage Description	NJ FamilyCare D
Premium	None	None	\$15 per Family per month Member Cost Sharing. Never to exceed 5% of Annual Income.	Premium	Sliding Scale \$30-\$100 per month, per family, based on income level.
Annual Deductible	None	None	None	Annual Deductible	None.
Coinsurance	None	None	None	Coinsurance	None.
Personal Care Contribution	None	None	Where specified below.	Co-Payment	Where specified below.
Lifetime Maximum	Unlimited	None	Family limit on all cost sharing equal to 5% of income.	Lifetime Maximum	No cost sharing above 5% of total family income per year.
Inpatient Hospital Services	Covered	Covered	Covered	Inpatient Hospital Services	Covered.
Outpatient Hospital Services	Covered	Covered	Covered	Outpatient Hospital Services	Covered. \$5 co-payment.
Emergency Room Services	Covered for emergency service only.	Covered for Emergency Services Only	\$10 Personal Care Contribution. Covered for Emergency Services Only	Emergency Room Services	\$35 co-payment. No co-payment if referred by PCP and waived if admitted.
Lab and X-Ray	Covered	Covered	Covered	Lab and X-Ray	Covered. \$5 co-payment that is not part of office visit.
Nursing Facility Services	Covered Medicaid fee-for-service, up to 30 days admission. Member disenrolled on 31st day.	Covered Medicaid fee-for-service, up to 30 days admission. Member disenrolled on 31st day.	Covered Medicaid fee-for-service, up to 30 days admission. Member disenrolled on 31st day.	Nursing Facility Services	Covered Medicaid fee-for-service, for up to a 30 day admission. Member disenrolled on 31st day.
Physician's Services	Covered	Covered	Covered - \$5 Personal Care Contribution per visit. No copayments for well-child visits in accordance with the schedule recommended by the American Academy of Pediatrics; Lead screening and treatment; age appropriate immunizations; prenatal care; pap smea	Physician's Services	Covered. \$5 co-payment.
Home Health Care	Covered. Fee-for-service Medicaid for the non-dually eligible ABD population.	Covered. Fee-for-service Medicaid for the non-dually eligible ABD population.	Covered. Fee-for-service Medicaid for the non-dually eligible ABD population.	Home Health Care	Covered for skilled nursing services only.
Personal Care	Covered, Medicaid Fee-for-service.	Not Covered	Not Covered	Personal Care	Not covered
Medical Day Care	Covered, Medicaid Fee-for-service.	Not Covered	Not Covered	Medical Day Care	Not covered
Hospice Services	Covered - when Medically Certified	Covered - when Medically Certified	Covered - when Medically Certified	Hospice Services	Covered when medically necessary.
Podiatry Services	Covered. Excludes hygienic care of the feet.	Covered. Excludes hygienic care of the feet.	Covered - \$5 Personal Care Contribution. Excludes hygienic care of the feet.	Podiatry Services	Covered. \$5 co-payment; excludes hygienic care of the feet.
Optometric Services	Covered	Covered	Covered - \$5 Personal Care Contribution	Optometric Services	Covered. \$5 co-payment; included one routine eye exam per year.
Chiropractic Services	Covered	Covered	Covered - \$5 Personal Care Contribution	Chiropractic Services	Not covered.
Physical, Occupational and Speech Therapy	Covered - Fee-for -Service Medicaid	Covered - Limited to 60 days per therapy per year. Fee-for Service Medicaid	Covered - \$5 Personal Care Contribution. Limited to 60 days per therapy per year. Fee-for-service Medicaid.	Physical, Occupational and Speech Therapy	\$5 copayment. Covered, Medicaid Fee-for-service. Limited to 60 days per therapy per year.
Prescription Drugs	Covered - includes over-the-counter drugs for children.	Covered	Covered - Personal Care Contribution of \$1 for generic and \$5 for Brand name drugs. Includes insulin, needles and syringes.	Prescription Drugs	Covered. Excludes over-the-counter drugs. \$5 co-payment, except \$10 co-payment if greater than a 34-day supply.
Prosthetics and Orthotics	Covered	Covered	Covered	Initial Prosthetics and Repair and Replacement due to congenital growth.	Covered. (Orthotics not covered)
Ambulance (emergency or transport) Durable Medical Equipment	Covered	Covered	Covered	Ambulance (emergency or transport) Durable Medical Equipment	Limited to ambulance for medical emergency only. Not covered.
Private Duty Nursing	Covered when medically necessary and approved by UHP.	Covered when medically necessary and approved by UHP.	Covered when medically necessary and approved by UHP.	Private Duty Nursing	Not covered unless authorized by UHP.
Organ Transplants	Covered - Excludes experimental	Covered - Excludes experimental	Covered - Excludes experimental	Organ Transplants	Covered, excluding experimental or investigational; donor and beneficiary in-patient hospital services.
Home Dialysis	Covered	Covered	Covered	Second Opinion Consultation	Covered
Second Opinion Consultation	Covered. Limited to certain medical conditions.	Covered. Limited to certain medical conditions.	Covered. Limited to certain medical conditions.	Mental Health - Inpatient	Covered. Fee-for-service Medicaid. Disenrolled from UHP on date of admission. 35 days per year limit.
Mental Health - Inpatient	Covered. Fee-for-service Medicaid. Disenrolled from UHP on date of admission.	Covered. Fee-for-service Medicaid. Disenrolled from UHP on date of admission.	Covered. Fee-for-service Medicaid. Disenrolled from UHP on date of admission.	Mental Health - Outpatient	Covered under Medicaid fee for service (\$25 co-payment). Limit to 20 visits per year.
Mental Health - Outpatient	Covered, Medicaid Fee-for-service.	Covered, Medicaid Fee-for-service.	Covered, Medicaid Fee-for-service.	Mental Health - DDD Clients	Covered
Mental Health - DDD Clients	Covered	Covered	Covered	Alcohol and Chemical Dependency - Inpatient	Covered under Medicaid fee for service for detoxification only.
Alcohol and Chemical Dependency - Inpatient	Covered, Medicaid Fee-for-service. DDD beneficiaries covered by UHP.	Covered, Medicaid Fee-for-service.	Covered, Medicaid Fee-for-service.	Alcohol and Chemical Dependency - Outpatient	Covered under Medicaid fee for service (\$5 co-payment) for detoxification only.
Alcohol and Chemical Dependency - Outpatient	Covered, Medicaid fee-for-service.	Covered, Medicaid Fee-for-service.	Covered, Medicaid Fee-for-service.	Prenatal Support Services	Covered.
Prenatal Support Services	Covered via Health Start	Covered via Health Start	Covered via Health Start	Nurse Midwifery Services	Covered - \$5 Personal Care Contribution unless for Pre-natal Care

Coverage Description	NJ FamilyCare A	NJ FamilyCare B	NJ FamilyCare C	NJ FamilyCare D
Nurse Midwifery Services	Covered	Covered	Covered	Covered. \$5 co-payment. After office hours, \$10 co-payment.
Nurse Practitioner Services	Covered	Covered	Covered - \$5 Personal Care Contribution	Covered. \$5 co-payment. After office hours, \$10 co-payment.
Federally Qualified Health Centers	Covered	Covered	Covered - \$5 Personal Care Contribution	Covered, except for infertility treatments. Fee-for-service Medicaid when furnished by non-participating provider.
Family Planning	Services and supplies covered except for infertility treatment. Covered Fee-for-service Medicaid when furnished by non-participating provider.	Covered except for infertility treatment. Fee-for-service Medicaid when furnished by non-participating provider.	Covered except for infertility treatment. Fee-for-service Medicaid when furnished by non-participating provider.	Not covered, except for well child care, including immunizations and lead screening treatments.
EPSDT - Early and Periodic Screening, Diagnosis and Treatment Services	Covered - including all allowable services necessary to improve a condition or defect whether or not covered by the State plan.	EPSDT exams, dental, vision, hearing services, Lead screening and treatment, age appropriate immunizations, and pap smears are covered. Certain treatment services which are not covered in plan or Medicaid Fee for Service are not covered.	EPSDT exams, dental, vision, hearing services, Lead screening and treatment, age appropriate immunizations, and pap smears are covered. Certain treatment services which are not covered in plan or Medicaid Fee for Service are not covered.	Not covered.
School-Based Rehab Services	Covered	Covered	Covered	Not covered.
Targeted Case Management	Covered for chronically mentally ill	Covered for chronically mentally ill	Covered for chronically mentally ill	Not covered.
Hearing Aid Services	Covered	Covered	Covered	Not Covered.
Audiology Services	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologists	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologists	Covered when provided in a clinic, hospital or office of licensed otologists or otolaryngologists	Covered. Limited to one pair of glasses (or contact lenses) per 24 month period or as medically necessary.
Optical Appliances/Eyeglasses	Covered	Covered	Covered	Not covered. Limited to ambulance for medical emergency only.
Invalid Coach Transportation	Covered	Covered	Covered	Not covered. Limited to ambulance for medical emergency only.
Lower Mode/Livery Transportation	Covered, Medicaid fee-for-service.	Not Covered	Not Covered	Limited to preventive dental services for children under the age of 12 years, including oral examinations, oral prophylaxis and topical applications.
Dental	Covered - including orthodontia and dentures (medical/surgical services of dentist are mandatory)	Covered	Covered - \$5 Personal Care Contribution applies, unless the visit is for preventive dentistry services	Covered.
Preventive Services	Covered	Covered	Covered	Not Covered.
Catastrophic Coverage	Not Applicable	Not Applicable	Not Applicable	Covered for administration fee only.
Blood and Blood Plasma	Covered	Covered	Covered	Limited to diabetic supplies only.
Medical Supplies	Covered	Covered	Covered	Covered, Medicaid Fee-for-service.
Abortions and Related Services	Covered, Medicaid Fee-for-service.	Covered, Medicaid Fee-for-service.	Covered, Medicaid Fee-for-service.	Not covered

## General Information

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### NJ FamilyCare Membership ID Card Description



- A. Member's Name
- B. Member's ID Number
- C. Primary Care Provider
- D. Primary Care Provider's Telephone Number

- E. Effective Date
- F. Member's Date of Birth
- G. Group Number
- H. Co-Pay Dollar Amounts