

Date

"[Click here and type Recipients Name]"
[Click here and type address]
[Click here and type City, State and Zipcode]

Dear [Click here and type] :

This letter will serve as an introduction to INETICARE Disease Management and me, [Click here and type], your Nurse Care Manager. INETICARE is a medical Care Management company used by [Click here and type] on behalf of your employer group, [Click here and type] to provide assistance to individuals who may experience difficulties with certain medical conditions. As patient advocates, Nurse Care Managers work with patients, their physicians, and families in coordinating necessary education, care and services that may be necessary both now and in the future months. It is my job to serve as a liaison between you, your family and your care providers and the health plan. It is my role to help coordinate the provision of the highest quality, most appropriate healthcare for you and to work with you to obtain and maintain your optimal level of wellness through education regarding your disease and its management. Our goal is for you to be able to successfully and confidently manage your health and your healthcare needs.

I am sending you information regarding INETICARE Care Management along with a consent form. **Please sign and return either a copy or the original consent to me as soon as possible in the enclosed self-addressed stamped envelope.** This consent form will allow me to discuss your care with your health care providers.

This completely **voluntary** service is at **no cost** to you and is provided through the benefit plan. It is not a "hands on" service, nor is it intended to interrupt or interfere with any care you are now receiving. You may dis-enroll at any time without penalty.

In order to determine specifically how we may be of assistance, I will be contacting you in the very near future or you are welcome to call me at 877-608-2200 (toll free) ext. [Click here and type], at your earliest convenience if you have any questions or concerns. Please accept my assurance that every effort will be extended on your behalf to ensure an optimal recovery.

Regards,

[Click here and type]
CARE MANAGER

Enclosure (2)

The CARE MANAGER's Role, The Services That Will Be Provided, And The Goals Of Care Management

Important Information

Telephonic access-The CARE MANAGER is available during normal business hours (Monday-Friday, 9:00 a.m.-5:00 p.m. ET). However, upon agreement by all parties, communication may be conducted outside of normal business hours. To reach your CARE MANAGER, dial the toll free number provided to you in your introduction letter that accompanies the authorization for release of information sent to you upon initiation of Care Management services. If the CARE MANAGER is not available or is on another line assisting another patient, you may leave a message on the confidential voice mail that is available 24 hrs/day-7 days/week. If you have a rotary phone, have hearing issues, or are unable to speak English, please notify us by mail or via email at nursing@ineticare.com.

Role-The nurse CARE MANAGER works as your advocate, facilitating coordination of education, care, and communication among your care providers, the payer, and you.

Services-The CARE MANAGER does not provide "hands-on" care. All services provided are provided to you on a **voluntary** basis. The CARE MANAGER does not interfere in your physician's treatment plan; rather, she or he assists the physician and other providers in assuring that the care provided is timely, of high quality, and appropriate.

Goals

- Assurance of Quality of Care-ensuring that the you receive quality, cost-effective medical care and treatment appropriate to your condition
- Assurance of Quality of Life-making sure that you and your family are informed and supported throughout the disease process
- Reduced health care costs for you, the patient with a chronic illness, by promoting appropriate use of health care resources, education, and self-care knowledge.

Third Party Involvement – Patients are identified for Care Management services through utilization review, case management, your providers, the insurer's benefit verification process and/or claims review, by the employer, or through a call from the patient or his family or the providers.

Registering a Complaint – If you are not satisfied with the services you are receiving or have any concerns, please notify INETICARE's Quality Assurance Supervisor, 877-258-2200 (toll free) to register a complaint.

INETICARE's DISEASE MANAGEMENT PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

- The right to know about the philosophy and characteristics of INETICARE's disease management program;
- The right to have personally identifiable health information shared by INETICARE's disease management program only in accordance with state and federal law;
- The right to identify the staff member and their job title, and to speak to a supervisor of the staff member if requested;
- The right to receive accurate information from INETICARE's disease management program;
- The right to receive administrative information regarding changes in or termination of INETICARE's disease management program;
- The right to decline participation, revoke consent or dis-enroll at any point in time;
- The responsibility to submit any forms that are necessary to participate in the program, to the extent required by law;
- The responsibility to give accurate clinical and contact information and to notify INETICARE's disease management program of changes in this information; and the responsibility to notify your treating provider of your participation in the disease management program (if applicable).

Registering a Complaint – If you are not satisfied with the services you are receiving or have any concerns, please notify INETICO's Quality Assurance Supervisor via telephone 1-877-608-2200 (toll free), mail POB 10972 Tampa, FL 33679-0972, or email quality@ineticare.com to register a complaint

- The responsibility to follow instructions, advice, and guidelines agreed upon with those providing your healthcare and disease management services. These instructions MAY include, but are not limited to, the following:
 - a. Follow exercise and dietary guidelines
 - b. Daily monitoring (ex. Blood glucose monitoring, peak flow readings, blood pressure) as prescribed
 - c. Consistent use of prescribed medication
 - d. Schedule and keep follow-up appointments
 - e. Obtaining recommended screenings according to the disease-specific standards of care
 - f. Use your primary physician or a specialist plan and coordinate your care
 - g. Know the goals and targets you have agreed to with your physician; know your current status in order to make lifestyle modifications to meet those goals and targets
 - h. Actively participate in your disease management program by following prescribed treatments and recommendations, reading and applying written and verbal information provided to you, and giving feedback to the disease management staff and your treating physician regarding your progress
 - i. Notify INETICARE and your treating physician if you decide to dis-enroll from the disease management program
- The right to information, in an understandable form, about all disease management-related treatment options included in clinical practice guidelines whether or not they are covered under your benefit plan. You are encouraged to discuss treatment options with your treating practitioners.
- You will be treated privately, with courtesy and respect.
- You have the right to file a complaint or grievance according to the procedure set forth in your benefit plan documents if you experience a problem with any service or with the organization (call the number on the back of your ID Card and/or Call INETICARE toll-free at 1-877-608-2200 or email INETICARE at quality@ineticare.com .

If you do not want to participate in the disease management program, have questions about any of your Rights and Responsibilities, or feel you have been incorrectly placed in a disease management program, call INETICARE toll-free at 1-877-608-2200, 9:00 a.m.-5:00 p.m. Monday-Friday Eastern Time. Voice mail is available 24 hours per day-seven days per week. If you are hearing impaired, please notify us via email at nursing@ineticare.com or quality@ineticare.com or via mail at INETICARE POB 10972 Tampa, FL 33679.

If you have an urgent situation that is not a medical emergency, you may call the number on the back of your member ID card.

If you have a medical emergency, you should contact your physician and/or call emergency services for assistance at 9-1-1.

You may find more information about INETICARE and INETICO AT www.inetico.com or www.ineticare.com .

Disease Management Consent and Release of Information Form

I, "[Click here and type NAME, Date of Birth, PID]" agree to participate in the Disease Management Program administered by INETICARE for "[Click here and type name of the insurer and group #"] .

CHECK ONE OF THE TWO OPTIONS BELOW

I understand that this agreement to participate means:

- I consent to the patient and/or family being contacted by the Care Manager assigned by **INETICARE.**
- I consent to providers of health care services (hospital staff, physicians, therapist, etc.) being contacted for information about the patient for the development, implementation and evaluation of a Disease Management Program Care Plan and for the processing of claims for the services provided under the Program.
- I understand that INETICARE will release only information necessary for appropriate benefit management and/or to arrange medical and/or social services.
- I authorize the release of medical information from all my health care providers (hospital staff, physicians, therapist, etc.) for the purpose stated above to INETICARE and its representatives according to HIPAA regulations. This information may be released by my attending physician or other medical professionals who have treated me. This information specifically may include details relating to alcohol or drug treatment, mental health treatment, communicable-diseases such as hepatitis or HIV, or any other medical condition or treatment. I fully understand that the intent of this authorization to secure information is solely for the purpose of Disease Management and/or rehabilitation plan development on behalf of [Click here and type Client/Designee].
- I understand that the Disease Management Program is voluntary and I may withdraw from the program at any time upon notification to **INETICARE's** Care Manager. If I withdraw, my contract benefits, as described in the Benefit Booklet, will continue.
- I understand that the information that is disclosed in accordance with this authorization may be disclosed by the recipient to the payer and that the information may no longer be protected by Federal privacy rules regarding protected health information.
- I understand that I should retain a copy of this document for my records and that a photocopy of this form is as valid as the original.
- I have read the above (or the above has been explained to me) and I hereby agree to participate in the Disease Management Program and am bound by the contractual provisions of my health insurance contract.
- I understand the information provided or explained to me regarding the Program.
- I understand that involvement in the Disease Management Program provides the program with the ability to communicate with treating providers for urgent or non-urgent circumstances or to discuss variances in the treatment plan.
- I understand that if I am dissatisfied with the care or services, for any reason, I can call the **INETICARE** Care Manager or Quality Assurance Department at **877-608-2200**(toll free), Monday through Friday, between the hours of 9:00 am and 5:00 pm ET.

I choose **NOT** to accept Disease Management services.

Signature

Relationship to Patient

Date

If signing for a minor child, please state your relationship (e.g. Mother, Father, guardian, etc.) If signing on behalf of someone else, such as a spouse, please state your relationship and the reason the person/insured is unable to sign for him/her.

This consent is valid for one year post signature.

If someone else is signing this authorization form on behalf of the member, please provide the following:

*Legal Representative's name: _____ Relationship to the member: _____ Note:

*Please provide written documentation to support your status as a guardian or other legal representative.

Please complete and return in the enclosed stamped self-addressed envelope upon receipt or within fifteen (15) calendar days of receipt of letter. This consent is valid for one year post signature.

Registering a Complaint - If you are not satisfied with the services you are receiving or have any concerns, please notify INETICO's Quality Assurance Supervisor via telephone 1-877-608-2200 (toll free), mail POB 10972 Tampa, FL 33679-0972, or email quality@ineticare.com to register a complaint

HEALTH CARE CONSUMER BILL OF RIGHTS

The Consumer Bill of Rights has three goals:

- To strengthen consumer confidence by assuring that the health care system is fair and responsive. It provides consumers with effective ways to address their concerns, and encourages them to take an active role in improving and assuring their health.
- To reaffirm the importance of a strong relationship between patients and their health care providers.
- To reaffirm the critical role that consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants.

Here is a summary of the eight areas of consumer rights and responsibilities.

1. Information disclosure

"You have the right to receive accurate and easily understood information about your health plan, health care professionals and health care facilities."

This information is included:

- Details from your health insurance plan about what is covered, how much you will pay and how to resolve complaints you may have
- Background on your health care providers, including their education, board certification, years of practice and experience
- Details about the health care facility, including experience in performing certain procedures and services; accreditation status; measures of quality and worker and consumer satisfaction; and procedures for resolving complaints
- If you speak another language, have a physical or mental disability or don't understand something, you can get assistance to help you can make informed decisions.

2. Choice of providers

"You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality health care."

- To ensure choice, your insurance plan should provide access to sufficient numbers and types of providers to assure that all covered services will be accessible without unreasonable delay. This includes access to emergency services 24 hours a day, seven days a week, and specialists for women's health and serious medical conditions.
- If you involuntarily change health plans, and are undergoing treatment for a chronic or disabling condition, or are in the second or third trimester of a pregnancy, you should be able to continue seeing your specialist for up to 90 days or until postpartum care is completed.

3. Participation in treatment decisions

"You have the right to know all your treatment options and to participate in decisions about your care. Parents, guardians, family members or other individuals that you designate can represent you if you cannot make your own decisions."

To ensure the ability to participate in treatment decisions, health care professionals should discuss all treatment options, including the option of no treatment at all. Your health plan, providers and health care facility should tell you about any factors that could influence their advice or treatment decisions. These factors include methods of compensation, ownership of or interest in health care facilities, or matters of conscience.

4. Respect and nondiscrimination

"You have a right to considerate, respectful and nondiscriminatory care from your doctors, health plan representatives and other health care providers."

You must not be discriminated against in the marketing, enrollment or delivery of health care services, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation or source of payment.

5. Confidentiality of health information

"You have the right to talk in confidence with health care providers and to have your health care information protected. You also have the right to review and copy your own medical record and request that your physician amend your record if it is not accurate, relevant or complete."

To ensure this right, health care providers give consumers a HIPAA-approved form that spells out privacy considerations.

6. Complaints and appeals

“You have the right to a fair, fast and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.”

7. Consumer responsibilities

“In a health care system that protects consumers' rights, it is reasonable to expect and encourage consumers to assume reasonable responsibilities.”

These are examples of consumer responsibilities:

- Adopting healthy habits, such as exercising and not smoking.
- Becoming involved in health care decisions. You should disclose relevant information and clearly communicate your wants and needs.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.

8. Other Consumer Responsibilities

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal process to address concerns that may arise.
- Avoid knowingly spreading disease.
- Become knowledgeable about his or her health plan coverage and health plan options (when available) including all covered benefits, limitations and exclusions, rules regarding use of information, and the process to appeal coverage decisions.
- Show respect for other patients and health workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of the health plans and health care providers.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

BEING A SMART CONSUMER

FOR INFORMATION ON FINDING LEGAL ASSISTANCE

CONTACT YOUR LOCAL LEGAL AID OR THE AMERICAN BAR ASSOCIATION

<http://www.abanet.org>

If you have any questions, comments, or complaints regarding INETICARE's services, please contact our Quality Assurance Committee at: quality@ineticare.com or call (toll free) 1-877- 609-2200.

OTHER RESOURCES

- Consumer Bill of Rights and Responsibilities
 - www.hcqualitycommission.gov/cborr
- Federal Consumer Information Center
 - <http://www.pueblo.gsa.gov/>
- Consumer Product Safety Commission
 - <http://www.cpsc.gov/>
- Food and Drug Administration (FDA)
 - <http://www.fda.gov/>
- Federal Trade Commission (FTC)
 - <http://www.ftc.gov/>