Chapter 8: Your rights and responsibilities

[**Note:** Plans may add to or revise this chapter as needed to reflect NCQA-required language or language required by the Healthy Connections Medicaid program.]

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1."   
An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights.

# You have a right to get information in a way that meets your needs

[Plans may edit the section heading and content to reflect the types of alternate format materials available to plan members. Plans may not edit references to language except as noted below.]

[Plans must insert a translation of this section in all languages that meet the language threshold.]

We must tell you about the plan’s options, rules, and benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

* To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages. Our plan also has written materials available in Spanish. We can also give you information in Braille or large print. [If applicable, plans should insert information about the availability of written materials in other formats.]
* If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE   
  (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
* You can also call Healthy Connections Medicaid directly for help with problems. Here is how to get help from Healthy Connections Medicaid:
* Call the Healthy Connections Prime Advocate at 1-844-477-4632. They can help you understand the complaint process and tell you who can help.

# We must treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

* Race
* Ethnicity
* National origin
* Religion
* Sex
* Sexual orientation
* Age
* Mental ability
* Behavior
* Mental or physical disability
* Health status
* Receipt of health care
* Use of services
* Claims experience
* Appeals
* Medical history
* Genetic information
* Evidence of insurability
* Geographic location within the service area
* Source of payment

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation.

We cannot deny services to you or punish you for exercising your rights.

* For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services’ **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697). You can also call your local Office for Civil Rights. [Plans should insert contact information for the local office.]
* If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

# We must ensure that you get timely access to covered services and drugs

[Plans may edit this section to add specific requirements for minimum access to care and remedies.]

As a member of our plan:

* You have the right to choose a primary care provider (PCP) in the plan’s network. A *network provider* is a provider who works with the health plan.
* Call Member Services or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
* You have the right to a network of primary care and specialty providers who are capable of meeting your needs such as physical location, communication, and scheduling.
* [Plans may edit this sentence to add other types of providers that members may see without a referral.] You have the right to go to a gynecologist or another women’s health specialist without getting a referral. A *referral* is a written order from your primary care provider. [If applicable, replace the previous sentences with: We do not require you to get referrals. **or** We do not require you to go to network providers.]
* You have the right to get covered services from network providers within a reasonable amount of time.
* This includes the right to get timely services from specialists.
* If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
* You have the right to get emergency services or care that is urgently needed without prior approval.
* You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
* You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3 [plans may insert reference, as applicable].

Chapter 9 [plans may insert reference, as applicable] tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 [plans may insert reference, as applicable] also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

# We must protect your personal health information

We protect your personal health information as required by federal and state laws.

* Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
* You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the “Notice of Privacy Practice.” The notice also explains how we protect the privacy of your health information.

## How we protect your health information

* We make sure that unauthorized people do not see or change your records.
* In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first.* Written permission can be given by you or by someone who has the legal power to make decisions for you.
* There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
* We are required to release health information to government agencies that are checking on our quality of care.
* We are required to give Medicare or Healthy Connections Medicaid your health and drug information. If Medicare or Healthy Connections Medicaid releases your information for research or other uses, it will be done according to state and Federal laws.

## You have a right to see your medical records

* You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.
* You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
* You have the right to know if and how your health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Member Services.

[Plans may insert custom privacy practices.]

# We must give you information about the plan, its network providers, and your covered services

[Plans may edit the section to reflect the types of alternate-format materials available to plan members and/or languages primarily spoken in the plan’s service area.]

As a member of <plan name>, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at <phone number>. This is a free service. We also have written materials available in Spanish. We can also give you information in Braille or large print. [If applicable, plans should insert information about the availability of written materials in other formats.]

If you want any of the following, call Member Services:

* **Information about how to choose or change plans**
* **Information about our plan, including:**
* Financial information
* How the plan has been rated by plan members
* The number of appeals made by members
* How to leave the plan
* **Information about our network providers and our network pharmacies, including:**
* How to choose or change primary care providers
* The qualifications of our network providers and pharmacies
* How we pay the providers in our network

For a list of providers and pharmacies in the plan’s network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at <web address>.

* **Information about covered services and drugs and about rules you must follow, including:**
* Services and drugs covered by the plan
* Limits to your coverage and drugs
* Rules you must follow to get covered services and drugs
* **Information about why something is not covered and what you can do about it, including:**
* Asking us to put in writing why something is not covered
* Asking us to change a decision we made
* Asking us to pay for a bill you have received

As a member of <plan name>, you have the right to get timely information about any changes to the plan. This includes getting written information listed in your orientation materials once per year and being notified of any major changes in your orientation materials 30 days before those changes happen.

# Network providers cannot bill you directly

You have financial rights. Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7 [plans may insert reference, as applicable].

You have the right to be protected from paying any fees that <plan name> is responsible for.

You have the right to not be charged any cost sharing (copayments and deductibles) for Medicare Parts A and B services.

# You have the right to leave the plan at any time

No one can make you stay in our plan if you do not want to. You can leave the plan at any time. If you leave our plan, you will still be in the Medicare and Healthy Connections Medicaid programs. You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. If you leave the plan, you will receive your Healthy Connections Medicaid benefits the way you used to before you joined. They will be offered through Healthy Connections Medicaid fee-for-service.

# You have a right to make decisions about your health care

## You have the right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand*.

* **Know your health status.** You have the right to have complete and accurate information about your health status.
* **Know your choices.** You have the right to be told about all the kinds of treatment.
* **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
* **You can get a second opinion.** You have the right to see another doctor before deciding on treatment.
* **You can say “no.**” You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
* **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
* **You can ask us to cover a service or drug that was denied or is usually not covered.** Chapter 9 [plans may insert reference, as applicable] tells how to ask the plan for a coverage decision.
* **You should be encouraged to involve caregivers and family members in treatment discussions and decisions.**
* **You should be told in advance, in writing, if you are transferred to another treatment location and the reason for that transfer.**

## You have the right to say what you want to happen if you are unable to make health care decisions for yourself

[**Note:** Plans that would like to provide members with state-specific information about advance directives may do so. Include contact information for the appropriate state agency.]

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

* Fill out a written form to **give someone the right to make health care decisions for you**.
* **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an *advance directive.* There are different types of advance directives and different names for them. Examples are a *living will* and a *power of attorney for health care*.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

* **Get the form.** You can get a form from your doctor, your [care coordinator/care manager (plan’s preference)], a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Healthy Connections Medicaid, such as I-CARE (South Carolina’s State Health Insurance Program, or SHIP), may also have advance directive forms. [Insert if applicable: You can also contact Member Services to ask for the forms.]
* **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
* **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

* The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
* If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

***Remember, it is your choice to fill out an advance directive or not.***

## What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your [care coordinator/care manager (plan’s preference)] or the Healthy Connections Prime Advocate.

# You have the right to have a voice in how the plan is operated

If you have feedback on how the plan is operated today, please call Member Services at <phone number> to let us know.

# You have the right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 [plans may insert reference, as applicable] tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

## What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—andit is *not* about discrimination for the reasons listed on page <page number>—you can get help in these ways:

* You can **call Member Services**.
* You can **call I-CARE,** **the State Health Insurance Assistance Program (SHIP)**. For details about this organization and how to contact it, see Chapter 2 [plans may insert reference, as applicable].
* You can call the **Healthy Connections Prime Advocate.** For details about this organization and how to contact it, see Chapter 2 [plans may insert reference, as applicable].
* You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
* You can call **Healthy Connections Medicaid** at 1-888-549-0820, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-753-8583.

## How to get more information about your rights

There are several ways to get more information about your rights:

* You can **call Member Services**.
* You can **call I-CARE, the State Health Insurance Assistance Program (SHIP)**. For details about this organization and how to contact it, see Chapter 2 [plans may insert reference, as applicable].
* You can call the **Healthy Connections Prime Advocate.** For details about this organization and how to contact it, see Chapter 2 [plans may insert reference, as applicable].
* You can **contact** **Medicare**.
* You can visit the Medicare website to read or download “Medicare Rights & Protections.” (Go to http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
* Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days   
  a week. TTY users should call 1-877-486-2048.
* You can **call Healthy Connections Medicaid** at 1-888-549-0820, Monday through Friday from 8 a.m. to 6 p.m. TTY users should call 1-800-753-8583.

# You also have responsibilities as a member of the plan

[Plans may modify this section to include additional member responsibilities.]

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

* **Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.**
* For details about your covered services, see Chapters 3 and 4 [plans may insert reference, as applicable]. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
* For details about your covered drugs, see Chapters 5 and 6 [plans may insert reference, as applicable].
* **Participate in an initial health screen upon enrollment in the plan.** For more information, see Chapter 1 [plans may insert reference, as applicable] or call Member Services.
* **Participate in a comprehensive assessment within the first 60 or 90 days of enrollment.** For more information, see Chapter 1 [plans may insert reference, as applicable] or call Member Services.
* **Tell us about any other health or prescription drug coverage you have.**Please call Member Services to let us know.
* We are required to make sure that you are using all of your coverage options when you receive health care. This is called *coordination of benefits.*
* For more information about coordination of benefits, see Chapter 1 [plans may insert reference, as applicable].
* **Tell your doctor and other health care providers that you are enrolled in our plan.**Show your plan ID card whenever you get services or drugs.
* **Help your doctors and other health care providers give you the best care.**
* Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
* Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
* If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
* **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor’s office, hospitals, and other providers’ offices.
* [Plans may edit as needed to reflect the costs applicable to their members.]   
  **Pay what you owe.** As a plan member, you are responsible for these payments:
* Medicare Part A and Medicare Part B premiums. For most <plan name> members, Healthy Connections Medicaid pays for your Part A premium and for your Part B premium.
* [Delete this bullet if the plan does not have cost sharing:] For some of your [insert if the plan has cost sharing for long-term services and supports: long-term services and supports or] drugs covered by the plan, you must pay your share of the cost when you get the [insert if the plan has cost sharing for services: service or] drug. This will be a [insert as appropriate: co-pay (a fixed amount) **or** coinsurance (a percentage of the total cost)]. [Insert if the plan has cost sharing for long-term services and supports: Chapter 4 [plans may insert reference, as applicable] tells what you must pay for your long-term services and supports.] Chapter 6 [plans may insert reference, as applicable] tells what you must pay for your drugs.
* If you get any services or drugs that are not covered by our plan, you must pay the full cost.

If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9 [plans may insert reference, as applicable] to learn how to make an appeal.

* **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
* **If you move *outside* of our plan service area, youcannot be a member of our plan.** Chapter 1 [plans may insert reference, as applicable] tells about our service area. We can help you figure out whether you are moving outside our service area. [Plans that do not offer plans outside the service area may delete the following sentence:] During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Healthy Connections Medicaid know your new address when you move. See Chapter 2 [plans may insert reference, as applicable] for phone numbers for Medicare and Healthy Connections Medicaid.
* **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
* **Pay estate recovery amounts after your death**
* Estate recovery is the amount that certain members owe Healthy Connections Medicaid after their death.
* You will not owe our plan any money, but you may owe money to Healthy Connections Medicaid for services received before you joined our plan.
* The plan is not allowed to collect estate recoveries after your death, but we will notify Healthy Connections Medicaid that you have died.
* If you owe Healthy Connections Medicaid money when you die, the state may collect estate recoveries from money or property you leave behind.
* **Call Member Services for help if you have questions or concerns.**