Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a Member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

[**Note:** Plan may add to or revise this chapter as needed to reflect NCQA-required language or language required by state Medicaid programs.]

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

[Plan must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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

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

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

We must tell you about the plan’s 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 can also give you materials [plan must insert if they are required to provide materials in any non-English languages: in languages other than English and] in formats such as large print, braille, or audio. [Plan must specifically state which languages are offered. *Plan also must simply describe:*
* *how it will request a member’s preferred language other than English and/or alternate format,*
* *how it will keep the member’s information as a standing request for future mailings and communications so the member does not need to make a separate request each time,* ***and***
* *how a member can change a standing request for preferred language and/or format*.]

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, 7 days a week. TTY users should call 1-877-486-2048. [Plan should insert information about filing a complaint with Medicaid.]

# Our responsibility to ensure that you get timely access to covered services and drugs

[The plan 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. You can find more information about choosing a PCP in Chapter 3 [plan may insert reference, as applicable].
* Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which providers are accepting new patients.
* [Plan may edit this sentence to add other types of providers that members may use without a referral.] You have the right to go to a behavioral health provider or a women’s health specialist without getting a referral. A referral is approval from your PCP to use someone that is not your PCP. [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 use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3 [plan may insert reference, as applicable].

Chapter 9 [plan 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 [plan 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.

# Our responsibility to protect your personal health information (PHI)

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

Your PHI 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 PHI 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 PHI.

## C1. How we protect your PHI

We make sure that unauthorized people do not look at 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 PHI to government agencies that are checking on our quality of care.
* We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws. [Plan may insert similar information about sharing medical records with Medicaid as appropriate.]

## C2. You have a right to look at 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 PHI has been shared with others.

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

[The plan may insert custom privacy practices.]

# Our responsibility to give you information about the plan, its network providers, and your covered services

[Plan 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 <toll-free number>. This is a free service. [Plan must insert information about the availability of written materials in languages other than English, stating specifically what languages are offered.] We can also give you information in large print, braille, or audio. [If applicable, plan should insert information about the availability of written materials in other formats.]

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

* 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
* Our network providers and our network pharmacies, including:
* How to choose or change primary care providers
* Qualifications of our network providers and pharmacies
* How we pay providers in our network
* For a list of providers and pharmacies in the plan’s network, refer to the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at <web address>.
* 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
* Why something is not covered and what you can do about it, including asking us to:
* Put in writing why something is not covered
* Change a decision we made
* Pay for a bill you got

# <Plan name’s> quality improvement program

[*Plan should insert clear, concise information about its quality improvement program.*]

# Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay less than the provider charged us. The only exception to this is if you are getting long-term services and supports (LTSS) and Rhode Island Medicaid says that you have to pay part of the cost of these services. This is called “cost-share,” and the amount is determined by Rhode Island Medicaid. To learn what to do if a network provider tries to charge you for covered services, refer to Chapter 7 [plan may insert reference, as applicable].

# Your right to leave the plan

No one can make you stay in our plan if you do not want to.

* 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.
* Refer to Chapter 10 [plan may insert reference, as applicable] for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
* If you leave our plan, you will get your Medicaid services directly through Rhode Island Medicaid Fee for Service (FFS). For more information about Rhode Island Medicaid FFS, call <phone number> <days and hours of operation>.

# Your right to make decisions about your health care

## H1. Your 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 provider must explain your condition and your treatment choices in a way that you can understand. You have the right to:

* **Know your choices.** You have the right to be told about all kinds of treatment for your health conditions.
* **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.
* **Get a second opinion.** You have the right to go to another provider before deciding on treatment.
* **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 provider 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.
* **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.
* **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 [plan may insert reference, as applicable] tells how to ask the plan for a coverage decision.

## H2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

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

Sometimes people are unable to make health 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 provider 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 provider, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid [plan should insert examples of those organizations] 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 provider. 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.

## H3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a provider or hospital did not follow the instructions in it, you may file a complaint with [plan should insert the name and contact information of the applicable state-specific agency (such as the State Department of Health)].

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

Chapter 9 [plan 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.

## I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed on page <page number> – or you would like more information about your rights, you can get help by calling:

* Member Services.
* The POINT at 1-401-462-4444 (TTY 711). The POINT provides information and referrals for programs and services for seniors, adults with disabilities, and their caregivers.
* Medicare at 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 also read or download “Medicare Rights & Protections,” found on the Medicare website at [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)
* RIPIN Healthcare Advocate. For details about this organization and how to contact it, refer to Chapter 2 [plan may insert reference, as applicable].
* The Alliance for Better Long Term Care. For details about this organization and how to contact it, refer to Chapter 2 [plan may insert reference, as applicable].

[If applicable, the plan should insert additional contact information, such as for the state Medicaid agency.]

# Your responsibilities as a Member of the plan

[The plan may modify this section to include additional member responsibilities. Plan may add information about estate recovery and other requirements mandated by the state.]

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.
* Covered services, refer to Chapters 3 and 4 [plan 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.
* Covered drugs, refer to Chapters 5 and 6 [plan may insert reference, as applicable].
* **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
* **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member 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.
* [Plan 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, 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 or drugs: 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: copay (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 [plan may insert reference, as applicable] tells what you must pay for your long-term services and supports.] Chapter 6 [plan may insert reference, as applicable] tells what you must pay for your drugs.
* If you get LTSS, you may have to pay for part of the cost of your services. This is called “cost-share,” and the amount is determined by Rhode Island Medicaid.
* **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 refer to Chapter 9 [plan 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 service area, you cannot stay in this plan.** Only people who live in our service area can get <plan name>. Chapter 1 [plan may insert reference, as applicable] tells about our service area.
* We can help you figure out whether you are moving outside our service area. 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.
* Also, be sure to let Medicare and Medicaid know your new address when you move. Refer to Chapter 2 [plan may insert reference, as applicable] for phone numbers for Medicare and 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.
* Call Member Services for help if you have questions or concerns.

# What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

* Call us at <plan name> Member Services. Phone numbers are at the bottom of this page.
* Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
* [Plan may also insert additional State-based and plan resources for reporting fraud.]