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:** 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, "refer to Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

[*Plans 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 services and 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 ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also 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 free interpreter services available to answer questions in different languages.
* Our plan can also give you materials for free in Spanish and in formats such as large print, braille, or audio. [*Plans must specifically state which other languages are offered. Plans also must simply describe:*
  + *how they will request a member’s preferred language other than English and/or alternate format,*
  + *how they 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.
* Medicaid at [Plans should insert information about filing a complaint with Medicaid.]
* Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.
* 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. TTY users should call 711.

[*Plans should ensure that the beginning of Section B and the list of reasons remain together on the same page. If necessary, plans should insert a page break before Section B begins.*]

# Our responsibility to 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. You can find more information about choosing a PCP in Chapter 3 [*plans may insert reference, as applicable*].
* Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and 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 use without a referral.] You have the right to use 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 use 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 (PA).
* 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 [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.

# 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 related to your 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.

Except for the cases noted below, we do not give your PHI 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 or Healthy Connections Medicaid your PHI. If Medicare or Healthy Connections Medicaid releases your PHI for research or other uses, it will be done according to federal and state laws.

## 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.

[Plans may insert custom privacy practices.]

# Our responsibility to 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 large print, braille, or audio. [If applicable, plans should insert information about the availability of written materials in other formats.]

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

* How to choose or change plans
* 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
* A list of providers and pharmacies in the plan’s network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services or visit our website listed at the bottom of the page.
* Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and 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 (refer to Chapter 9), including asking us to:
* Put in writing why something is not covered
* Change a decision we made
* Pay for a bill you got

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.

# Inability of network providers to 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, refer to 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 (copays 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 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 get your Healthy Connections Medicaid benefits the way you used to before you joined. They will be offered through Healthy Connections Medicaid fee-for-service.
* Refer to Chapter 10 [plans may insert reference, as applicable] for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.

# Your right to make decisions about your health care

## G1. 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. Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

* **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.
* **Get a second opinion.** You have the right to use another doctor 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 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.
* **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 [plans may insert reference, as applicable] tells how to ask the plan for a coverage decision.
* **Be encouraged to involve caregivers and family members in treatment discussions and decisions.**
* **Be told in advance, in writing, if you are transferred to another treatment location and the reason for that transfer.**

## G2. Your 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. 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.

## G3. 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.

# Your 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 the number at the bottom of the page to let us know.

# Your 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.

## 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 in Chapter 11 of this handbook – or you would like more information about your rights, you can get help by calling:

* Member Services.
* I-CARE, the State Health Insurance Assistance Program (SHIP). For details about this organization and how to contact it, refer to Chapter 2 [plans may insert reference, as applicable].
* The Healthy Connections Prime Advocate. For details about this organization and how to contact it, refer to Chapter 2 [plans may insert reference, as applicable].
* 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](https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)
* 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 1-888-842-3620.

# Your 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, refer to 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.
* Covered drugs, refer to Chapters 5 and 6 [plans may insert reference, as applicable].
* **Participate in an initial health screen** upon enrollment in the plan. For more information, refer to 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, refer to Chapter 1 [plans may insert reference, as applicable] or call Member Services.
* **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.
* [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 almost all <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]].
* **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 [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. Refer to 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 you 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.