MHT/WVHB Members' Rights and Responsibilities Statement

Statement of Members' Rights

- Receive information about The Health Plan, its services, practitioners, and your rights and responsibilities according to contract standards. We will provide this information upon enrollment, annually, and at least 30 days prior to any change. The Health Plan will provide all information according to the requirements of state law and the contract. Please see the benefit grid for covered services according to the contract.
- Be able to request and receive your medical records, and to request they be amended or corrected and receive prompt action in a timely manner of no later than 30 days from receipt of the request for records and no later than 60 days from the receipt of a request for amendments.
- Know you have the right to privacy and confidentiality with regard to your personal information. Information about your medical history and enrollment file is private. You have the right to approve or refuse the release of personal information by The Health Plan, unless the law or this agreement requires it.
- Be able to discuss appropriate or medically necessary treatment options for your condition(s) with your practitioner, even if they are not covered by The Health Plan. However, if you or your practitioners prefer a certain treatment and it is not covered by The Health Plan, you could be responsible for the cost. This information will be presented in a manner appropriate to the enrollee's condition and ability to understand. Your appropriate behavior, such as keeping appointments, helps in this decision-making. However, this does not expand coverage by the Plan.
- Receive medical advice or options communicated to you without any limitations or restrictions being placed upon the practitioner or PCP by the HMO.
- Be treated with respect, dignity, and privacy by The Health Plan employees, practitioners, and their staff. If you feel that your treatment has not been respectful, please call The Health Plan Customer Service Department at 1.888.613.8385.
- Get prompt resolution of issues raised, including complaints or grievances and issues relating to authorization, coverage, or payment of services. There are informal and formal steps available to you to resolve all complaints/grievances without reprisal from the health maintenance organization (HMO).
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
- Change your PCP at any time by calling or writing The Health Plan. The new PCP has to be available.
- Choose a participating PCP and OB/GYN and, with proper referrals, see a participating specialist.
- Be able to refuse care from the designated practitioner and select a different affiliated practitioner.
- Know how to obtain out-of-area services.

- Help make decisions about your health care when possible and within the plan guidelines as outlined in this agreement, including the right to refuse treatment.
- Make an advance directive.
- Tell us your comments, opinions or complaints about The Health Plan or your medical care.
- Have coverage denials involving medical necessity or experimental treatment reviewed, after exhaustion of the HMO's internal grievance procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care service, as part of an external review.
- Know how you can get a list of the plan's practitioner network, including the names and credentials of all participating practitioners. You should know how to choose practitioners within the plan. If you have any questions regarding the qualifications of any plan physician, please contact The Health Plan's Customer Service Department at 1.888.613.8385.
- Know you are free to exercise your rights. Exercising these rights does not adversely affect our treatment of you.
- Know how to obtain access to a summary of the plan's accreditation report.
- Health care professionals, acting within the lawful scope of practice, are not prohibited or restricted from advising or advocating on behalf of an enrollee's health status; medical care or treatment options (including any alternative treatment that may be self-administered); any information the enrollee needs for deciding among all relevant treatment options; or the risks, benefits, and consequences of treatment or no treatment.
- Know that you will not be discriminated against in the delivery of health care services consistent with the benefits covered in your policy, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, being homeless, sexual orientation, genetic information, or source of payment.
- Know you have full disclosure from your health care practitioner of any information relating to your medical condition or treatment plan and the ability to examine and offer corrections to your own medical records.
- Access emergency health care services, consistent with your determination of the need for such services as a prudent layperson, and post-stabilization services. No referral is needed.
- Know you can file a grievance for an administrative or medical complaint. You will continue to get good care and be treated with respect, even if you file a complaint.
- Receive continuation of benefits while your appeal is pending; however, you may have to pay for the cost of continuation benefits if the appeal is upheld.
- Be able to have a practitioner or medical professional review any coverage denials according to The Health Plan review procedures.
- Get a second opinion from a qualified health care professional within or outside the network, at no cost to you. This second opinion could be in addition to that of a specialist referred by the PCP.
- Have all coverage denials reviewed by appropriate medical professionals consistent with the HMO's review procedures.
- Be informed of plan policies and any charges for which you may be responsible.

- A woman has the right to direct access, annually, to her OB/GYN for the purpose of a well woman examination without a referral from her PCP, and no woman shall be required to obtain a referral from her PCP as a condition to coverage of prenatal or obstetrical care.
- A woman whose plan provides coverage for surgical services in an inpatient or outpatient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.
- A woman whose plan provides coverage for laboratory or X-ray services has a right to the following when performed for cancer screening or diagnostic purposes: (1) a baseline mammogram for women age 35 to 39, inclusive; (2) a mammogram for women age 40 to 49, inclusive, at least every two years; (3) a mammogram every year for women age 50 and over; (4) a pap smear at least annually for women age 18 and over.
- A nonsymptomatic person over 50 years of age and a symptomatic person under 50 years of age have the right to colorectal cancer examinations and laboratory tests for colorectal cancer.
- Be able to have rehabilitation services.
- Receive child immunization services, which shall not be subject to payment of any deductible, per-visit charge and/or copayment.

A diabetic whose health benefits policy includes eye care benefits, has the right to direct access to an optometrist or ophthalmologist of their choice from the panel without referral from their PCP for an annual diabetic retinal examination. When the diabetic retinal examination reveals the beginning stages of an abnormal condition, access to future examinations shall be subject to prior authorization from a PCP.

Statement of Members' Responsibilities

For The Health Plan to provide appropriate and medically necessary health care services and to allow you to get the most from your plan membership, we want to work together with you and your family. Please share in responsibilities by doing the following:

- Pick a PCP. You should keep a relationship with a PCP. The PCP will be the manager and medical home for all your health care needs.
- Identify yourself as a THP member to avoid mistakes when you go to the practitioner or see another practitioner.
- ***Always*** carry The Health Plan ID and Medicaid medical cards. ***Never*** let anyone else use them.
- Read this handbook. You should follow the guidelines and contact The Health Plan for help, if needed.
- Let The Health Plan know any changes in the following:
    - Name, address, telephone number.
    - Number of dependents (marriage, divorce, new baby, child leaves home, etc.).
    - Loss of ID card.
    - Change of PCP.

- Be on time for appointments. If you cannot keep an appointment, call and cancel.
- Give details about your health to the physicians. This information is needed for the diagnosis and treatment of medical problems.
- Follow directions given by your practitioners, such as what medicines to take or what foods you should eat.
- If you get emergency care outside The Health Plan service area, call The Health Plan within 48 hours.
- You must talk with your PCP or OB/GYN before receiving specialty care or services.
- You must give The Health Plan information on other insurance you have or if you have worker's comp or if you're in an accident. You may have to pay The Health Plan money owed under Coordination of Benefits or Subrogation policies.
- Please be friendly to The Health Plan's employees, practitioners and their staff.

Medicaid Members' Rights and Responsibilities

Your Rights

As a member of The Health Plan, you have rights around your health care and to receive information according to contract standards. Each year, The Health Plan submits its annual report to the Bureau for Medical Services (BMS) by April 1st. This reports includes a description of the services, personnel and the financial standing of THP.

The annual report is available to members by request only. To get a copy of the report, you can call Member Services at 1.888.613.8385. You can also get a copy of the report from BMS.

You have the right to:

- Ask for and obtain all included information
- Be told about your rights and responsibilities
- Get information about The Health Plan, our services, our providers, and your rights
- Be treated with respect and dignity
- Not be discriminated against by The Health Plan
- Access all services that The Health Plan must provide
- Choose a provider in our network
- Take part in decisions about your health care
- Refuse treatment and choose a different provider
- Get information according to the member's ability to understand on treatment options and different courses of care
- Have your privacy respected
- Ask for and to get your medical records within 30 days of request
- Ask that your medical records be changed or corrected if needed within 60 days of request
- Be sure your medical records will be kept private
- Recommend changes in policies and procedures
- Be free from any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation
- Get covered services, no matter what cultural or ethnic background or how well you understand English
- Get covered services regardless of if you have a physical or mental disability, or if you are homeless
- Refer yourself to in-network and out-of-network family planning providers
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services
- Get emergency post-stabilization services

- Get emergency health care services at any hospital or other setting
- Accept or refuse medical or surgical treatment under State law and to make an advance directive
- Have your parent or a representative make treatment decisions when you can't
- Make complaints and appeals
- Get a quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services
- Ask for a state fair hearing after a decision has been made about your appeal
- Request and get a copy of this member handbook annually after initial enrollment
- Disenroll from your health plan
- To exercise your rights. Exercising these rights does not adversely affect our treatment of you.
- Ask us about our Quality Improvement program and tell us how you would like to see changes made.
- Ask us about our utilization review process and give us ideas on how to change it.
- Know the date you joined our health plan
- Know that we only cover health care services that are part of your plan
- Know that we can make changes to your health plan benefits as long as we tell you about those changes in writing
- Get news on how providers are paid
- Find out how we decide if new technology or treatment should be part of a benefit
- Ask for oral interpreter and translation services at no cost to you
- Use interpreters who are not your family members or friends
- Know you will not be held liable if your health plan becomes bankrupt (insolvent)
- Know your provider can challenge the denial of service with your permission

Your Responsibilities

As a member of The Health Plan, you also have some responsibilities:

- Read through and follow the instructions in this handbook
- Work with your PCP to manage and improve your health
- Ask your PCP any questions you may have
- Call your PCP at any time when you need health care
- Give information about your health to The Health Plan and your PCP
- Always remember to carry your member ID card
- Only use the emergency room for real emergencies
- Keep your appointments

- If you must cancel an appointment, call your PCP as soon as you can to let him or her know
- Follow your PCPs recommendations about appointments and medicine
- Go back to your PCP or ask for a second opinion if you do not get better
- Call Member Services at 1.888.613.8385 whenever anything is unclear to you or you have questions
- Treat health care staff and others with respect
- Tell us right away if you get a bill that you should not have gotten or if you have a complaint.
- Tell us and your DHHR caseworker right away if you have had a transplant or if you are told you need a transplant.
- Tell us and DHHR when you change your address, family status or other health care coverage.
- Know that we do not take the place of workers' compensation insurance