MEMBERS’ RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members’ Rights

A member has the right to receive information regarding the description of their rights & responsibilities, a summary of The Health Plan’s (THP) accreditation report and services, policies, plan benefits, limitations, premiums and individual cost-sharing requirements. A member has the right to obtain evidence of medical credentials of a network provider (e.g., diplomas and board certifications) and the method by which they may choose providers within THP.

A member’s personal choice of a primary care physician (PCP) enables the member to participate in the management of his/her total health care needs including the right to refuse care from a specific practitioner. A member has the right to choose an available participating primary care physician (PCP) and with proper pre-authorization, the right to a network specialist. A member of THP is encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. A member may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician). They have the right to a description of the procedures for obtaining out-of-network services.

A member can expect to receive courteous and personal attention and to be treated with dignity. THP employees, providers, and their staff will respect a member’s privacy.

A member has the right to privacy and confidentiality with regard to their personal information. They have the right to be informed of THP’s policies and any changes for which they will be responsible. A member has the right to full disclosure from their health care provider of any information relating to their medical condition or treatment plan and the ability to examine and offer corrections to their own medical records in accordance with applicable federal and state law. A member has a right to approve or refuse the release of personal information by THP except when the release is required by law. THP ensures that all patient information, medical history and enrollment files are held in the strictest confidence. All staff at THP must adhere to THP’s confidentiality policy adopted in November 1996 and reviewed every three years, unless warranted otherwise. This statement acknowledges the confidential nature of the review work, includes an agreement to honor that confidentiality, and documents the consequences of failing to do so. THP will not release personal health information to an employer, or its designee, without a signed THP authorization form by the member. For information on obtaining medical records, contact The Health Plan Customer Services Department.

A member has the right to express their comments, opinions or complaints about THP or the care provided and to file an appeal for an administrative or medical complaint and hearing procedures without the reprisal from THP. A member also has the right to have coverage denials reviewed by the appropriate medical professional consistent with THP review procedures. Both informal and formal steps are available to members.
to resolve all complaints/appeals. They have the right to have coverage denials involving medical necessity or experimental treatments reviewed, after exhaustion of THP’s internal appeal procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care services, as part of an external review.

A member may participate in decision-making about their health care when possible and within THP guidelines. They have the right to discuss with providers, without limitations or restrictions being placed upon the providers, appropriate or medically necessary treatment options for their condition(s) regardless of cost or benefit coverage. However, this does not expand coverage by THP. A member also has the right to formulate advance directives.

A member has the right to emergency services without prior authorization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed, and the right to a description of procedures to obtain emergency services.

A female member has the right to direct access, annually, to her OB/GYN for the purpose of a well woman examination without pre-authorization from her PCP, and no female shall be required to obtain pre-authorization from her PCP as a condition to coverage of prenatal or obstetrical care.

A female member 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 person convicted of a crime involving family violence.

A female member whose plan provides coverage for laboratory or radiology 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 50 and over; 4) a Pap smear at least annually for women age 18 and over.

A non-symptomatic member over 50 years of age and a symptomatic member under 50 years of age have the right to colorectal cancer examinations and laboratory tests for colorectal cancer.

A member has the right to rehabilitation services.

A member has the right to child immunization services, which shall not be subject to payment of any deductible, copayment or co-insurance payment, per visit charge.

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

A member has the right to have a meaningful voice in the organization by expressing their suggestions and comments regarding their coverage, policies, member rights and responsibilities, and operations. Member comments and opinions are received by The
Health Plan through yearly member satisfaction surveys, phone calls from our members, and focus groups.

If a member needs assistance with any of the above, they may contact our Customer Services Department at 1.800.624.6961 (TTY: 711). A member can also contact us via our website at healthplan.org.

Statement of Members’ Responsibilities

Some members must choose a primary care physician (PCP) for each person listed on THP’s ID card. A member has a responsibility to maintain a relationship with their PCP, as the PCP will act as the coordinator for all his/her health care needs.

A member must identify him/herself as a member of THP to avoid unnecessary errors; always carry their ID card; and never permit anyone else to use their ID card.

A member is asked, through “outreach calls” to new members, to read their member handbook and understand the benefits and procedures for receiving health care services. To ensure maximum coverage, a member has a responsibility to follow the rules and to contact THP for assistance, if necessary.

A member is required to notify THP of any changes in the following:

- Names, address, phone number;
- Dependent information to include: marriage, divorce, newborn or other newly acquired dependents, ineligible dependents;
- Loss of ID card; and
- Selection of PCP.

A member is asked to be on time for appointments and to call the physician’s office promptly if the appointment can’t be kept.

A member must provide necessary information to the providers rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions.

A member must understand health problems and participate in developing mutually agreed upon treatment goals, to the highest degree possible, and follow those instructions and guidelines given by those providers who deliver health care services.

If a member receives emergency care outside the THP network, they are required to contact THP within 48 hours or as soon as reasonably possible.

A member must contact their PCP, secondary care physician (SCP) or OB/GYN before seeking any specialty care services.

A member must provide THP with all relevant, correct information and pay THP any money owed according to coordination of benefits (COB) or subrogation policies.

A member must make required deductible, copayments or co-insurance payments under the “Schedule of Benefits” in the member handbook.

A member is asked to be courteous and respectful of THP employees, providers, and staff.
The Health Plan’s Affirmative Statement Regarding Incentives

The Health Plan (THP) bases its decision-making for coverage of health care services on medical appropriateness utilizing nationally recognized criteria.

Incentives are not offered to providers or THP employees involved in the review process for issuing non-authorization.

Also, no incentives are given that foster inappropriate under-utilization by provider, nor does THP condone under-utilization, nor inappropriate restrictions of health care services.