HEALTH PLAN POLICY		
Policy Title: Member Rights and Responsibilities		**Policy Number:** OPMS14 **Revision:** E
Department: Operations	**Sub-Department:** Member Services	
Applies to Product Lines: ☐Medicaid ☐Children's Health Insurance Plan ☒Health Insurance Exchange ☒Medicare		☒USFHP ☒Commercial Insured ☒Non Insured Business
Origination/Effective Date: 12/09/2014		
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SCOPE:

This policy outlines the requirements for the health plan to protect the rights and responsibilities of its members. The health plan will distribute the rights and responsibilities as documented in the member handbook or Evidence of Coverage (EOC) as defined below.

DEFINITIONS AND ACRONYMS:

- **Centers for Medicare and Medicaid Services (CMS)** – The federal agency responsible for administering the Medicare and Medicaid programs.
- **Evidence of Coverage (EOC)** – A document mailed to enrolled members that provides details about the what the plan covers, what is not covered, how much the member will pay and other details about the plan.
- **Tricare Management Activity (TMA) -** The department that manages the Tricare program under the authority of the Assistant Secretary of Defense (Health Affairs). Tricare is a health care program of the United States Department of Defense Military Health System. It provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component.

POLICY:

The health plans will include a statement of member rights and responsibilities that clearly outline the commitment to treating members in a manner that respects their rights, and explains the expectations of the member responsibilities. The health plans will distribute this information to new members when they enroll, existing members annually, new physicians when they join the network, and existing physicians annually.

Monitoring:

The Center for Medicare & Medicaid Services (CMS) and the Tricare Management Activity (TMA) must approve any updates or changes to the member's rights and responsibility statement. The health plan conducts internal reviews of the policies and procedures annually. CMS and TMA will conduct their own audits at any given time.

Member Rights and Responsibilities

Customer rights and responsibilities — Medicare

Medicare customers have the right:

- To be treated with respect and understand their need for privacy and dignity.
- To get help in a prompt, courteous, responsible and culturally competent manner.
- To be given information about their health care benefits.
- To be given information about any limitations and services not covered by the plan.
- To be told by their Provider all of their medical information in words they understand.
- To talk with their Provider about their care.
- To expect the health plan not to interfere with any contracted Providers talking with them about their treatment choices.
- To have the health plan send them to another contracted Provider if he/she does not agree to a treatment because of moral or religious grounds.
- To be given information about the list of contracted Providers in their service area.
- To be told by their Provider about any treatment they may get.
- To have their Provider ask for their permission for all treatment, unless there is an emergency and they cannot sign a consent form and their health is in serious danger.
- To refuse treatment, including any trial treatment, and be told of the possible outcome of their choice.
- To choose an advance directive to pick the kind of care they wish to get if they become unable to express their wishes.
- To select, without interference, a primary care Provider of their choice from the health plan's list of contracted Providers.
- To make suggestions about the member rights and responsibilities policy.
- To file a complaint about the health plan.
- To file a complaint about the care they have received and to get a timely response.
- To file a grievance if they are not satisfied with their health plan's decision about their complaint.
- To get "timely access" to the records and information that pertains to them.

Medicare customers have the responsibility:

- To know and confirm your benefits before getting treatment.
- To show your member ID card before getting services.
- To protect your member ID card from being used by another person.
- To verify that the Provider you get services from is part of the health plan network.
- To keep scheduled appointments.
- To pay any copayments/coinsurance at the time you get treatment.
- To ask questions and understand the care you are getting.
- To follow the advice of your Provider and be aware of the possible outcomes if you do not.
- To tell us your opinions, concerns and complaints.
- To give information when asked to the health plan and contracted Providers that would help improve your health status.

- To use emergency room services only for an injury or illness that you might think may be a serious threat to your life or health.
- To follow the treatment plan agreed upon by you and your Provider.
- To give all the health plan staff respect and courtesy.
- To tell us of any change in address.

If you have questions or concerns about your rights, please call CHRISTUS Health Plan Generations (HMO) Customer Service at the phone number listed on the back of your member ID card. If you need help with communication, such as help from a language interpreter, customer service can assist you.

The Medicare program has written a booklet called *Your Medicare Rights and Protection*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or TTY (1-877-486-2048) 24 hours a day, 7 days a week. Or you can access the Medicare website, to order the booklet or print it from your computer.

In addition, Medicare members have the following rights:

Grievances

- The right to have grievances heard and resolved in accordance with health plan guidelines;
- The right to request quality of care grievance data from their health plan; and
- The right to file a quality of care grievance with a QIO.

Organization Determinations

- The right to a timely organization determination;
- The right to request an expedited organization determination, or an extension; and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.
- The right to a written notice from their health plan of its own decision to take an extension on a request for an organization determination that explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension.
- The right to receive information from their health plan regarding the member's ability to obtain a detailed written notice from their health plan regarding the member's services; and
- The right to a detailed written notice of their health plan's decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment which includes the member's appeal rights.

Appeals

- The right to request an expedited reconsideration;
- The right to request and receive appeal data from their health plan;

- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE);
- The right to automatic reconsideration by an IRE contracted by CMS, when the health plan upholds its original adverse determination in whole or in part;
- The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement;
- The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part;
- The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the member, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement;
- The right to request a QIO review of a termination of coverage of inpatient hospital care. If a member receives immediate QIO review of a determination of non-coverage of inpatient hospital care, the above rights are limited. In this case, the member is not entitled to the additional review of the issue by the health plan. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Members may submit requests for QIO review of determinations of non-coverage of inpatient hospital care;
- The right to request a QIO review of a termination of services in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities. If a member receives QIO review of a SNF, HHA or CORF service termination, the member is not entitled to the additional review of the issue by their health plan. Members may submit requests for QIO review of provider settings;
- The right to request and be given timely access to the member's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. The Medicare health plan shall have the right to charge the member a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material. At the time the request for case file material is made, the health plan should inform the member of the per page duplicating cost. Based on the extent of the case file material requested, the Medicare health plan should provide an estimate of the total duplicating cost for which the member will be responsible. The health plan may also charge the member the cost of mailing the material to the address specified. If member case files are stored off- site, then the Medicare health plan may not charge the member an additional cost for courier delivery to a plan location that would be over and above the cost of mailing the material to the member; and
- The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The new coverage challenge process is available to both beneficiaries with original Medicare and those enrolled in Medicare health plans.

Member Rights and Responsibilities - HIX

As a Member of the HIX Plan, You have the right to:

1. Available and accessible services for medically necessary and covered services, including 24 hours per day, 7 days per week for urgent or emergency services, and for other health care services as defined by this policy or *Summary of Benefits and Coverage*.
2. Be treated in a prompt, courteous and responsible manner that respects your dignity and privacy.
3. Detailed information about your coverage; benefits; and services offered under this policy. This includes any exclusions of specific conditions; ailments or disorders, including restricted prescription benefits; the plan's policies and procedures regarding products, services, providers appeal procedures and other information about the plan and the benefits we provide to you. This also includes access to a current list of participating providers in the plan's network; information about a particular participating provider's education, training, and practice; and the member rights and responsibilities, as well as the right to make recommendations regarding our member rights and responsibilities policies.
4. Affordable health care including information regarding your out-of-pocket expenses; limitations; the right to seek care from a non-participating provider; and an explanation of your financial responsibility when services are provided by a non-participating provider or without prior authorization.
5. Choose a primary care provider within the limits of the covered services, the plan's network, and as provided by the policy, including the right to refuse care of specific health care professionals. In addition, you have the right to participate with your providers in making decisions about your health care.
6. Be given an explanation of your medical condition, recommended treatment, risks of the treatment, expected results, and reasonable medical alternatives by your participating provider in terms that you understand. If you are unable to understand the information, an explanation must be given to your next of kin, guardian or another authorized person. This information shall be documented in your medical records.
7. All rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to be informed about your treatment by your participating provider in terms that you understand; to request your consent (agreement) to the treatment; to refuse treatment, including medication; and to be told of possible consequences of refusing such treatment. This right exists even if treatment is not a covered benefit or medically necessary under the plan. The right to consent or agree to treatment by you or your next of kin, guardian, or another authorized person may not be possible in an emergency where your life and health are in serious danger.
8. Voice complaints, grievances or appeals with the plan or the Superintendent of Insurance (Superintendent) about the plan or the coverage we provide. You as a member also have the right to receive an answer within a reasonable time and in accordance with existing law and without fear of retaliation.
9. Be promptly notified of termination or changes in benefits, services or the provider network.
10. Confidential handling of all communications, including medical and financial information maintained by the plan. Privacy of your medical and financial records will be maintained by us and our providers in accordance with existing law.
11. A complete explanation of why a benefit is denied, the opportunity to appeal the denial decision, to our internal review and the right to request help from the Superintendent.

12. Know, upon request, of any financial arrangements or provisions between the plan and our participating providers, which may restrict referrals or treatment options or limit the services offered to you.
13. Qualified health care professionals for treatment and services that are covered benefits near where you live or work within the plan's service area.
14. Receive information about how benefits are authorized or denied. You have the right to know how new technology for covered benefits are evaluated. You can also request and receive information about the plan's quality assurance plan and utilization review methodology.

As a Member of the Plan, You have the responsibility to:

1. Provide honest and complete information to those providing you care.
2. Review and fully understand the information you receive about your plan.
3. Know the proper use of the services covered by the plan.
4. Present your plan ID card before you receive care.
5. Consult your physician before receiving medical care, unless your condition is life threatening.
6. Promptly notify your provider if you will be delayed or unable to keep an appointment.
7. Pay all charges or copay/coinsurance amounts, including those for missed appointments. This also applies to deductibles and any charges for non-covered benefits and services.
8. Express your opinions, complaints or concerns in a constructive way to the health plan member services or to your provider.
9. Inform the plan of any changes in family size, address, phone number or membership status within thirty (30) calendar days of the change.
10. Make premium payments on time.
11. Notify the plan of other insurance coverage.
12. Follow our grievance and appeal process when displeased with the plan or a provider's actions or decisions.
13. Understand your health problems and participate in developing treatment goals that you agree to with your providers.
14. Follow plans and instructions for care that you have agreed to with your provider and detailed information about all requirements that you must follow for prior authorization and utilization review.

Member Rights and Responsibilities – USFHP

The Plan supports the President's Advisory Commission on Consumer Protection. The Plan also supports the Health Care Industry's Consumer Bill of Rights and Responsibilities. This document is available at www.hcqualitycommission.gov.

The Plan declares the following rights and responsibilities of our members.

As a member of The Plan, you have the right to:

- Change your PCP once every 30 days.
- Attend all member meetings.
- Use all additional programs offered by The Plan.
- Submit a letter if a problem concerning your health care was not solved where it occurred. You can also talk with a patient advocate or Member Services representative about the problem.
- Call and speak with a nurse 24 hours a day by calling 1-800-455-9355.
- Have one complete eye exam each year.
- Have one annual physical each year.
- Get current information about the doctors and hospitals that participate in The Plan.
- Help your doctor make decisions about your health care.
- Know how to make appointments and get health care from your PCP during and after office hours.
- Know how to contact your PCP or their on-call support 24 hours a day, every day.

As a member of The Plan, you have a responsibility to:

- Pay your enrollment fees on time.
- Pay copayments required by The Plan.
- Not use Medicare Part A or B and Medicaid for services covered by The Plan.
- Update your military ID card as needed.
- Make sure that your DEERS information is correct and current.
- Notify Member Services at 1-800-678-7347 of a:
    - Change of address and/or phone number.
    - Change in eligibility for you or a family member.
- Disenroll from The Plan if you move outside of The Plan's service area.
- Provide The Plan with information if you are a member of other health insurance plans.
- Bring your member card with you when visiting your doctor, pharmacy or seeking medical treatment.
- Give your correct information to the provider any time a claim is filed. The needed information is:
    - The correct spelling of your first and last name.

  - Sponsor's Social Security number.
  - Your correct date of birth.
- Provide a complete medical history to your physician. This includes a list of all your medications (prescription and over-the-counter).

Use your plan PCP, plan network specialist (with referral), plan network hospital/facility and the network pharmacy for routine care.

Not use the Military Treatment Facility (MTF) or NMOP (National Mail-Order Pharmacy) for routine care.

Notify your PCP is possible before:

- Seeking emergency medical treatment.
- Seeking care outside of the service area (except when outside of the United States).

Notify The Plan at 1-800-678-7347 within 24 hours for:

- Emergency medical treatment.
- An accident requiring medical attention (motor vehicle accident, workers compensation, etc.).
- **Note:** Please notify The Plan as soon as possible. If you are unable to call immediately, pleae do so within 24 hours.

Transfer your medical record if it is necessary.

REFERENCES:

- Chapter 13, Section 10.3 Rights of Managed Care Enrollees
- Centers for Medicare & Medicaid Services, Your Medicare Rights and Protection http://www.medicare.gov/Pubs/pdf/11534.pdf
- US Family Health Plan Member Handbook, Member Rights and Responsibilities

RELATED DOCUMENTS:

None

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REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	12/09/2014	Initial release.	Board of Directors
A	09/29/2015	Added HIX rights and responsibilities.	Board of Directors
B	03/02/2017	Yearly Review. Updated to new template. Removed Madhavi Rajulapalli, M.D. and added David Engleking, M.D. as signatory.	Board of Directors
C	12/13/2017	Compliance Review- updated contents	Quality Improvement Committee
D	04/24/2019	Annual Review. No changes in content. Removed Medicaid and CHIP from lines of business. Corrected minor typos.	Executive Leadership
E	05/04/2020	Annual review. No changes in content.	Executive Leadership