Member Rights

You have a right to get information in a way that meets your needs
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 at 1-877-739-1370 (TTY: 711). From October 1 to March 31, we are open daily from 8:00 am to 8:00 pm, 7 days a week. From April 1 through September 30, we are open Monday through Friday, 8:00 am to 8:00 pm. On certain holidays and weekends from April 1 through September 30, your call will be handled by our automated phone system.

Our plan has people who can answer questions in different languages. We can also give you information in braille or large print.

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, seven days a week. TTY users should call 1-877-486-2048.
We must treat you with respect, fairness, and dignity at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate against members because of any of the following:

Race	Ethnicity	National origin	Religion
Sex	Sexual orientation	Age	Mental ability
Behavior	Mental or physical disability	Health status	Receipt of health care
Use of services	Claims experience	Appeals	Medical history
Genetic information	Evidence of insurability	Geographic location within the service area	

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.
We cannot deny services to you or prevent you from exercising your rights.
–For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697). You can also call your local Office for Civil Rights at 1-800-552-3431.
–If you have a disability and need help accessing care or a provider, call Member Services at 1-877-739-1370 (TTY: 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to covered services and drugs
If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
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.

- Call Member Services at 1-877-739-1370 (TTY: 711) or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- You have the right to go to a gynecologist or another women's health specialist without getting a prior authorization. A *prior authorization* is a written order from your primary care provider. We do not require you to get prior authorizations.
- 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.
- 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 see an out-of-network provider. To learn about out-of-network providers, see the Evidence of Coverage.

The Evidence of Coverage tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. The Evidence of Coverage also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

We must protect your personal health information

- We protect your personal health information as required by federal and state laws.
- Your personal health information 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 health information 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 health information.

How we protect your health information

- We make sure that unauthorized people do not see 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 health information to government agencies that are checking on our quality of care.
    - We are required to give Medicare your health and drug information. If Medicare releases your information for research or other uses, it will be done according to any applicable Federal and/or state laws.

You have a right to see 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 health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-877-739-1370 (TTY: 711).

We must give you information about the plan, its network providers, and your covered services

As a member of Virginia Premier, 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 1-877-739-1370 (TTY: 711). This is a free service. We can also give you information in Braille or large print.

If you want any of the following, call Member Services at 1-877-739-1370 (TTY: 711):

Information about how to choose or change plans Information about 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

Information about our network providers and our network pharmacies, including:

- How to choose or change primary care providers
- The qualifications of our network providers and pharmacies
- How we pay the providers in our network

Information about 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

Information about why something is not covered and what you can do about it, including:

- Asking us to put in writing why something is not covered
- Asking us to change a decision we made
- Asking us to pay for a bill you have received

For covered services:

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, see the Evidence of Coverage.

You have certain rights and responsibilities for disenrollment:

There are certain rights and responsibilities you have for disenrollment as a member of our plan. Please refer to the Disenrollment Rights and Responsibilities document.

You have a right to make decisions about your health care. You have the 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 providers must explain your condition and your treatment choices *in a way that you can understand*.

- 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.
- You can get a second opinion. You have the right to see another doctor before deciding on treatment.
- You can 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.
- You can 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.
- You can ask us to cover a service or drug that was denied or is usually not covered. The Evidence of Coverage tells how to ask the plan for a coverage decision.

You have the right to say what you want to happen if you are unable to make health care decisions for yourself.

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 the Virginia Advance Directive form at https://www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf. You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare (for example, Area Agencies on Aging, the Virginia Association of Community Service Boards, etc.) may also have advance directive forms. You can also contact Member Services 1-877-739-1370 (TTY: 711) 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. 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. You have the right to make complaints and to ask us to reconsider decisions we have made

The Evidence of Coverage 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 1-877-739-1370 (TTY: 711).

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly, you can get help in these ways:

- You can call Member Services 1-877-739-1370 (TTY: 711).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, see the Evidence of Coverage.
- You can call the Office of the Managed Care Ombudsman **or** the Office of the State Long-Term Care Ombudsman. For details about these organizations and how to contact them, see the Evidence of Coverage.
- You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can call Member Services 1-877-739-1370 (TTY: 711).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, see the Evidence of Coverage.
- You can call the Office of the Managed Care Ombudsman **or** the Office of the State Long-Term Care Ombudsman. For details about these organizations and how to contact them, see the Evidence of Coverage.
- You can contact Medicare.

You can visit the Medicare website to read or download "Medicare Rights & Protections." (Go to www.medicare.gov/Publications/Pubs/pdf/11534.pdf).

Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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 at 1-877-739-1370 (TTY: 711).

- Read the *Evidence of Coverage* to learn what is covered and what rules you need to follow to get covered services and drugs.
- For details about your covered services, see the Evidence of Coverage. It tells you what is covered, what is not covered, what rules you need to follow, what you pay and gives details about your covered drugs.
- Tell us about any other health or prescription drug coverage you have. Please call Member Services at 1-877-739-1370 (TTY: 711) to let us know.
- We are required to make sure that you are using all of your coverage options when you receive health care. This is called *coordination of benefits.*
- For more information about coordination of benefits, see the Evidence of Coverage.
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan 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.
- Pay what you owe. As a plan member, you are responsible for these payments:
- Medicare Part A and Medicare Part B premiums.
- For some of your long-term services and supports or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. Your Services will be paid in full once the patient pay responsibility is satisfied. This will be a co-pay (a fixed amount) or coinsurance (a percentage of the total cost). The Evidence of Coverage tells what you must pay for your long-term services and supports, it also tells what you must pay for your drugs.
- 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 see Evidence of Coverage to learn how to make an appeal.*
- Notify your eligibility worker at the Local Department of Social Services of any change in income, bonuses received, inheritance, etc.
- The Virginia Department of Medical Assistance Services pays a monthly premium to Virginia Premier for those with Medicare-Medicaid plan coverage. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your eligibility worker, you may have to repay the monthly premiums, even if you received no medical services during those months.
- Tell us if you move. If you are going to move, it is important to tell us right away. Call Member Services at 1-877-739-1370 (TTY: 711).

- If you move *outside* of our plan service area, you cannot be a member of our plan. We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area. Also, be sure to let Medicare know your new address when you move. See the Evidence of Coverage for phone numbers for Medicare.
- 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 at 1-877-739-1370 (TTY: 711) for help if you have questions or concerns.