
Overview

The Plan will ensure that members are aware of the role of Primary Care Physicians (PCPs), how to obtain care, what to do in an emergency or urgent medical situation and their rights and responsibilities. The Plan will convey this information through various methods including the Member Handbook.

Member Handbook

All newly enrolled members will receive a Member Handbook within 10 calendar days of receiving the notice of enrollment from the Plan.

Members receive an annual notice of their benefits and have the right to ask for basic information from the Plan.

Enrollment

Membership enrollment in the Plan is voluntary as members may select other Managed Care Organizations (MCOs) or may be randomly assigned to a MCO by the state.

Harmony Health Plan accepts all individuals without restrictions and abides by all federal and state laws and regulations that prohibit discrimination based on race, color, religion, sex, national origin, ancestry, age or physical or mental disability. Harmony will not tolerate discrimination against eligible or prospective members based on health status or need for health services.

Upon enrollment in the Plan, members are provided with the following:

- Terms and conditions of enrollment;
- Description of covered services;
- Information about PCPs; such as names, locations, telephone numbers, office hours and non-English languages spoken by affiliated providers;
- PCPs not accepting new patients;

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- Information regarding “out-of-plan” emergency services;
 - Grievance, appeal and disenrollment procedures;
 - Over-the-Counter brochure, if applicable;
 - Benefits, including benefits that are exclusively covered in addition under Harmony Health Plan;
 - How to utilize the benefits and usage of the Plan; and
 - Exclusions of the Plan benefits.

**Member Rights
and
Responsibilities**

Plan members, adults and children, have specific Rights and Responsibilities. These are included in the Member Handbook.

Harmony members have the right:

- To obtain information about Harmony – its services, its contracted doctors and providers and their rights and responsibilities.
- To choose any participating Primary Care Physician in the contracted network.
- Female enrollees have the right to choose a women’s health care provider (WHCP) as their PCP.
- To seek OB/GYN services on an annual, or as needed, basis.
- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

- To know the names, titles and credentials of doctors and other health care professionals involved in their care.
- To be treated with respect and dignity.
- To have the right to privacy.
- To take part with providers in making decisions about their health care, even if it means that the member may want coverage or services for items that are excluded from the Plan. The member has a right to understand all treatment plans, even if the plan involves a provider out-of-network. Providers must discuss all treatment plans even if they are investigational in nature.
- To talk openly about care they need for their health, regardless of cost or benefit coverage, as well as choices and risks involved. The information must be given to them in a way they understand.
- To have the risks, benefits and side effects of medications and other treatments clearly explained to them.
- To know about their health care needs after being released from a hospital or office.
- To refuse medical or surgical care, as long as they agree to be responsible for this decision.
- To refuse to take part in any medical research projects.
- To complain about Harmony or the care it provides, and to know that doing so will not affect how they are treated.
- To not be responsible for Harmony's debts in the event of insolvency or failure to pay.
- To be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or

retaliation.

- To have access to their medical records and to have those records kept private and confidential.
- To make their health care wishes known through advance directives.
- To have input into Harmony's members' rights and responsibilities policies.
- To appeal adverse medical or administrative decisions using Harmony's grievance process and the state process.
- To exercise these rights no matter what their sex, age, race, ethnic, economic, educational or religious background.
- To have all Harmony staff observe their rights.
- To have all the above rights apply to the person legally able to make decisions about their health care.

Members also have certain responsibilities. These include the responsibility:

- To give information that Harmony and its contracted doctors and providers need to provide care.
- To follow plans and instructions for care agreed upon with their doctor.
- To understand their health problems and share in developing treatment goals that they and their doctor agree to.
- To understand how Harmony works by reading the Member Handbook.
- To carry their member ID card and Medicaid ID card with them at all times. Show their ID cards to each provider (i.e., doctor, lab, hospital, pharmacy,

etc.) when services are being given.

- To schedule appointments for all non-emergency care through their assigned doctor, to get a referral from their doctor for specialty care and to cooperate with all persons providing care and treatment.
- To be on time for appointments.
- To notify the doctor's office if in need to cancel or reschedule an appointment.
- To pay co-payments to providers as specified by the program.
- To respect the rights, property and environment of all providers, employees and other patients and not be disruptive.
- To understand the medicines they take; to know what they are for and how to take them properly.
- To make sure their current doctor has been given copies of all previous medical records.
- To follow medical advice and treatment plans of their providers. Failure to follow medical treatment and continuously missed appointments when in the advice of their provider could be detrimental to their health. The member's provider will have the right to ask for a member transfer if certain medical criteria are not followed.

Medical Necessity

Members will be informed that *medically necessary* services are those that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition.
- Compatible with the standards of acceptable medical practice in the community.

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- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.
 - Not provided solely for the convenience of the member or the convenience of the health care provider or hospital.
 - Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage.

Emergency Services

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An *emergency medical condition* is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency; or
- Injury to self or bodily harm to others.

The Plan shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

Once the member's condition is stabilized, the Plan may require prior authorization for hospital admission or follow-up care.

Members have the right to use any type of provider, hospital or facility in the case of emergency. However, once the member is able to be medically transferred the member may be transferred to a hospital or facility where his/her PCP resides. In any case for covered services, the member will be sent to contracted providers unless it is necessary for him/her to be serviced by non-contracted providers.

Members are advised to seek care at the nearest medical facility or call 911 for emergency services. For non-emergent care, members should contact their PCP for medical advice. Harmony also has a nurse triage line that members may access.

**Member
Identification
Cards**

Member identification cards are intended to identify Plan members and facilitate their interactions with physicians and other health care providers. Information found on the member ID card may include the member's name, identification number, PCP's name and telephone number, co-payment information, health plan contact information and claims filing address.

Possession of the member ID card does not guarantee eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the cardholder. It is recommended that the provider verify eligibility by contacting Harmony or by calling the Provider Service Center.

**Eligibility
Verification**

A member's eligibility status can change at anytime. Therefore, all providers should consider requesting and copying a member's identification card along with additional proof of identification, such as a photo ID, and filing them in the patient's medical record.

PCPs may also refer to their current monthly membership listing to verify eligibility. If the member does not appear

on the list, you may do one of the following to verify eligibility:

- Access our Web site at www.harmonyhpi.com. (Contact your Provider Relations Representative to schedule a Web site in-service); or
- Contact the Provider Service Center.

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is never a guarantee of coverage or payment. See your Provider Agreement for additional details.

Assignment of Primary Care Physician

All Plan members must choose their PCP or they will be assigned to a PCP within the Plan's network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs, including providing primary care services and coordinating referrals to specialists and providers of ancillary or hospital services.

There are some services that the member can self-refer for under the Plan. Providers must refer patients to contracted Plan providers that are contracted and credentialed with Harmony. To determine if a provider is contracted and credentialed, please contact Harmony.

Hearing Impaired, Interpreter and Sign Language Services

Hearing impaired, interpreter and sign language services are available to Plan members through the Customer Service department. PCPs should coordinate these services for Plan members and contact the Plan's Customer Service department if assistance is needed. Please refer to the **Rapid Reference Guide** for the contact information.