

CONSUMER TIPS

From the Vermont Division of Health Care Administration

Consumer Bill of Rights

For Vermonters Covered by Managed Care Plans

Why a Bill of Rights?

If you aren't sure how managed care really works, or if you worry that going into a managed care plan means giving up important personal choices or getting less care than you need, then you need to know how the law protects you.

What is Managed Care?

In a managed care plan you choose your primary care doctor or other health care provider (often called a "primary care provider") from the plan's provider list (called a "network"). This person coordinates all decisions about the medical care you will get from a defined package of health benefits. Usually you will need to talk with your primary care provider first to get a referral before going to another provider or to the hospital.

It is important that you get all the information you can about a managed care plan both before and after you join. In deciding whether a specific managed care plan is right for you, you need to know: what providers (including specialists you may need) are in the plan's network, what is and is not covered in the benefits package, what the plan's rules are, and what you must do to get the health services you need.

Your Managed Care Rights Under Vermont Law

THE RIGHT TO INFORMATION: You have the right at any time to clear, understandable information about your plan that tells you how it works. You should understand:

- **What health care services are covered.**
- **Any limits on that coverage**, including rules that require you to get a referral before going to a doctor or hospital.
- **A current list of all health care providers and facilities** (such as hospitals) that are part of the plan's network. **Important note:** You have the right to change primary care providers **within** the plan's network.

- **A copy of the list of drugs** (called the "formulary") used by the plan. **Important note:** You have the right to get drugs that are not on the approved list if your doctor decides that the listed drugs have not helped you, or have hurt you.

THE RIGHT TO APPROPRIATE TREATMENT: You have the right to get health care services covered by your plan from the right kind of health care provider or treatment program at the right time. This includes:

- **The right to be seen by qualified doctors and other professionals, including specialists,** for all services covered by your managed care plan.
- **The right to get services within a reasonable distance and time,** depending on where you live or work. Generally, you should not have to travel more than 30 minutes to reach your primary care or mental health or substance abuse treatment provider, or 60 minutes to get to a hospital. You should be seen for urgent care within 24 hours, and within 2 weeks for routine care and referrals to specialists.
- **The right to prompt treatment for emergency or urgent health care needs.** Emergency services must always be available, even if you are outside your plan's usual service area. Plans must also pay for all emergency services you get for a sudden and unexpected health problem, even if you did not get the plan's permission to go to the emergency room, if you had a good reason to believe you would suffer serious health risks if you did not get care right away. **Important note:** Your managed care plan may ask you to call your doctor before going to the emergency room. Try to do this if you can, but **DO NOT DELAY** if you believe waiting to call your doctor could result in serious harm.
- **If you are a woman, you have the right to go directly to your gynecological health care provider** (an OB/GYN or Planned Parenthood, for example) at least twice a year without getting the plan's permission first. This includes any follow-up visits that you need for problems found during those visits.
- **If you have a condition that requires ongoing care from a specialist,** the plan must give you a "standing referral" that allows you to see your doctor for a number of visits over a period of time without having to get the plan's OK for each visit. **If you require a specialist for a life-threatening, degenerative or disabling condition,** you also have the right to use your specialist to coordinate all of your care, not just the care you need for that condition. **And if you need services from a type of specialist not in your plan's network,** the plan must pay for you to see that type of specialist outside its network.
- **If you have a life-threatening, degenerative or disabling condition and your specialist is not a member of your managed care plan's network,** you have the right to continue to see this provider for 60 days or until you are accepted by a new provider who is in the network, whichever comes first. Your first provider must agree to accept the plan's payment rates and quality standards and to provide necessary treatment information to the plan.

THE RIGHT TO ASK QUESTIONS OR FILE COMPLAINTS: You have the right to fully understand your health care needs and to complain to the plan if you do not receive services you or your doctor think are necessary. This includes:

- **The right to ask questions** and have your doctor advise you about your health care needs and all treatment choices, even if your plan won't pay for some of those treatments.
 - **The right to know the reason your managed care plan said "no" to a service** you or your doctor think you need. Plans must tell you, in writing, the medical reason for denying payment for a specific service, and tell you how to file a formal complaint (grievance) with the plan if you are unhappy with the decision.
 - **The right to file complaints with the managed care plan concerning a denial of service or problems in getting the kind, quality or amount of services you think you need.** If you cannot file a written complaint yourself, the plan must help you do it. If you ask for them, the managed care plan must give you copies of all records relating to your complaint at no cost to you.
 - **The right to have your complaint handled quickly.** Your managed care plan must review your case within certain time limits after gathering all the needed records. If your doctor thinks the situation is urgent, the plan has 3 days to get back to you. Otherwise, the plan has 15 days to answer medical complaints and 30 days to handle other kinds of complaints (like a delay in getting an appointment). If you are still unhappy with the result, you can ask for a second review, which has to be decided within 2 days (for emergency care) or 30 days (all other complaints).
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What to Do if You Are Denied Services You Think Your Managed Care Plan Should Cover

FIRST: Talk with your doctor or other health provider. Get help understanding the plan's decision. Your doctor should work with you to see that you get all medically necessary care. You can also call the Division of Health Care Administration's toll free help line at any time for advice or assistance at 1-800-631-7788. If you are insured through the Vermont Health Access Plan, you may want to call the Ombudsperson at 1-800-917-7787.

TO GO FURTHER: If after talking with your doctor you are still not satisfied, tell your managed care plan you want to file a complaint (grievance).

FINALLY: If you are unhappy with your managed care plan's decision regarding your complaint, you may have the right to get an independent review of that decision:

- **If you are insured through any Vermont Health Access Program (formerly Medicaid) you have the right to a fair hearing before the Human Services Board. Call toll-free at 1-800-250-8427.**
- **If you were denied coverage for a mental health or substance abuse problem, you have the right to a review by the Independent Panel of Mental Health Care Providers, no matter what managed care plan you have. Call 1-802-828-3301.**

Need more information? Need help?

Call the Division of Health Care Administration's Consumer Help Line
anytime:

1-800-631-7788

If you need this flyer in an alternative format please call 1-800-631-7788.

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