

How do I know if a certain procedure, surgery or service is covered by my health plan?



How do I obtain care and coverage when I am away from home?

Where do I find a claim form?



How can I obtain an independent external review of my denied claim or request for a service or procedure?

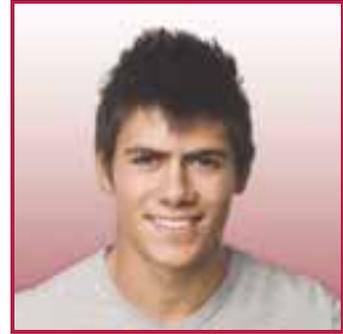


How do I obtain primary care services?

What are my rights as an ERISA plan member?



What happens if I don't go to doctors in my health plan?



Who do I contact about medical care and treatment processes?



What should I do if I believe my rights have been violated?



How do I exercise privacy rights?



How can I or my caregiver get help if I have a serious medical condition or a complex medical event?

What is an emergency?



How do I submit a claim?



How can I file an appeal?



What if I have questions about my prescription coverage?

Where can I find a list of doctors, hospitals or providers who are in my plan?

How do I get the most from my healthcare benefits?

How can I obtain care after normal office hours?



MEDICAL MUTUAL®

CAROLINA CARE PLAN | CONSUMERS LIFE

YOUR QUESTIONS ANSWERED



**answers** to your



Frequently  
Asked (**FAQ**)  
Questions.



KEEP THIS DOCUMENT FOR YOUR RECORDS



# MEDICAL MUTUAL®

CAROLINA CARE PLAN | CONSUMERS LIFE

Welcome!

At Medical Mutual® and its Family of Companies, we have a long-standing commitment to helping our members get the care they need by providing them with access to high-quality healthcare, a large network of doctors and hospitals, and a wide range of health programs.

As part of this commitment, we want to ensure our members understand and get the most out of the benefits we offer. To help you learn more about our services, we are providing this Frequently Asked Questions (FAQ) document as an easy-to-use, quick-reference guide.

If you are a current member and have additional questions, please visit one of our websites (listed below) and log on to *My Health Plan*, or call our dedicated Customer Service department at the number on your identification card. For information about your specific benefits, please refer to your Certificate or Benefit Book.



If you are not a current member, additional resources and information are available on our websites, or talk to your employer about the benefits available to you.

We look forward to serving your healthcare needs.

Sincerely,

Rick Chiricosta

President and Chief Executive Officer  
Medical Mutual and its Family of Companies

[CarolinaCarePlan.com](http://CarolinaCarePlan.com)

[MedMutual.com](http://MedMutual.com)

[ConsumersLife.com](http://ConsumersLife.com)

## What You Should Know About Your Health Benefits

Benefit Coverage.....	2	After-Hours and Emergency Care .....	5
Your Medical Care Costs.....	2	Filing a Complaint .....	6
Choosing a Physician.....	3	Filing a Member Appeal .....	7
Primary Care and Specialty Services .....	3	Assistance for Hearing or Speech Impaired .....	8
Receiving Medical Care .....	4	Member Rights and Responsibilities.....	9
Care and Case Management Phone Numbers.....	4	Privacy Rights .....	12
Submitting a Claim.....	5		

# Frequently Asked Questions



## How do I know if a certain procedure, surgery or service is covered by my health plan?

Covered benefits typically include medically necessary hospital stays and surgical procedures, diagnostic tests, visits to the doctor and routine preventive care. Some plans include prescription drug coverage.

“Medically necessary” (or “medical necessity”) is generally defined as a service, supply and/or prescription drug that is required to diagnose or treat a condition that we determine is:

- Appropriate with regard to the standards of good medical practice and not experimental or investigational;
- Not primarily for your convenience or the convenience of a provider; and
- The most appropriate supply or level of service that can be safely provided to you.

When applied to your care as an inpatient, this means your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an outpatient. When applied to prescription drugs, this means the prescription drug is cost effective compared to alternative prescription drugs that will produce comparable, effective clinical results.

*Check with your employer or your Certificate or Benefit Book to verify the services your plan covers these services.*

To check your covered benefits, review the *Schedule of Benefits* section in your Certificate or Benefit Book. Look in the *Exclusions* section for services not covered. Your Certificate or Benefit Book may also be available when you log on to your plan’s website or *My Health Plan*. Call Customer Service if your specific service is not listed in the schedule of benefits or exclusions.

Coverage exclusions typically include personal hygiene or convenience items, massotherapy, massage therapy, hypnosis, over-the-counter

drugs, vitamins or herbal remedies, cosmetic procedures or investigational/experimental treatments. Check with your employer or your Certificate or Benefit Book to verify if your plan covers these services.

## How does Medical Mutual determine if a new medical technology or procedure is covered?

When medical breakthroughs occur, we will perform an extensive evaluation of the new use and application of medical technologies, behavioral health procedures, pharmaceuticals and devices to ensure they are medically appropriate for our members. After multiple experts conduct this evaluation, a decision is made whether or not to include the new service in the coverage provided to our members. Coverage for new services may be limited to specific medical conditions, age groups, genders, places, types of service or diagnoses. Some services that are considered investigational and may not be covered can be found on *My Health Plan* by clicking on *Authorizations* under the *Support* tab.

## What charges am I responsible for when I receive services?

Depending on your health plan, you may be responsible for a copayment at each visit, an annual deductible, possibly a family deductible, coinsurance (the percentage of the provider’s bill you share with the insurer after you have met your deductible) up to your out-of-pocket maximum, charges for non-covered services and/or charges in excess of the allowed amount (if you go to a doctor or facility not in our network). For information on financial liability, contact your doctor for information about your diagnosis and expected procedures, and then call Customer Service for more information about covered services.

If you go to a doctor, hospital or facility for lab or radiological tests that is not in our network, you

may be billed the difference between what you were charged and what we allow for payment.

If you are an HMO or SuperMed HMO® health plan member and you see an out-of-network physician or specialist without an approved referral from your primary care physician, you will be responsible for all charges except in the event of a medical emergency.

### Where can I find a list of doctors, hospitals or providers who are in my plan?

To find a list of network providers:

- Log on to *My Health Plan* and select *Find a Doctor*
- Call Customer Service
- Call the applicable number on your ID card

### What happens if I don't go to doctors in my health plan?

Most plans require you to choose network doctors and hospitals to get the highest level of benefit.

If you choose to go outside of your network, you will be responsible for paying a non-network deductible and coinsurance (the percentage of the provider's bill you share with the insurer after you have met your deductible) and/or excess charges above the allowed amount we would normally pay for covered services. You would also pay for charges for non-covered services and for services we deny.

If you are a member of an HMO health plan, you do not have out-of-network coverage, other than for emergency services, and will be responsible for paying the charges in full.

### How can I find information about network doctors, hospitals and providers?

To find information and qualifications about providers in your health plan's network, call the provider's office or check:

- The *Find a Doctor* tool on *My Health Plan*
- Your local Academy of Medicine

- The State Medical Board
- The Directory of Medical Specialists, available at most public libraries
- The American Medical Association's Physician Select website: <https://extapps.ama-assn.org/doctorfinder/recaptcha.jsp>

*Get all your important health plan information in one secure, convenient online site, My Health Plan.*

### How do I obtain primary care services?

Primary healthcare services, like physical examinations and immunizations, are provided by practitioners who specialize in general medicine, family practice, internal medicine and pediatrics. Primary care services are typically provided in your primary care provider's office.



## Help Yourself to Your Health Information

Get all of your important health plan information in one secure, convenient online site — *My Health Plan* on [MedMutual.com](http://MedMutual.com), [CarolinaCarePlan.com](http://CarolinaCarePlan.com) and [ConsumersLife.com](http://ConsumersLife.com).

Through *My Health Plan*, not only can you stay up-to-date on your health benefits, but you also have access to a wealth of information and tools to help you save time and money.

With *My Health Plan* you can:

- Create your own account and grant your dependents equal access
- Access health plan details for you and your dependents
- Review your Explanation of Benefits (EOB) statements
- Track your medical and/or dental claims
- Locate network doctors and hospitals and estimate costs for visiting those providers
- Learn about health and wellness programs available to you
- Access the SuperWell® Health Resource Center for health information and interactive tools

*My Health Plan* is available to all members. Not registered? Create your account on *My Health Plan* today by clicking *Not a member? Register Now* under the login.

### How do I obtain specialty services, behavioral health services or hospital services?

Primary care providers can best advise from whom and when to obtain specialty services or behavioral health services, and when and where hospital services should be obtained. Check your Certificate or Benefit Book for mental health disorders and substance abuse benefits. Information about specialists may be found using the *Find a Doctor* tool on *My Health Plan*. Remember that any inpatient stay must have our prior approval.



### What does Medical Mutual do to improve the quality of healthcare?

We are committed to promoting and improving the quality of healthcare for members through our Quality Improvement Program, which monitors and evaluates the quality and safety of healthcare provided and communicates clinical information to members.

To ensure you receive appropriate medical care, we have a team that reviews certain tests, treatments or hospital stays in a process called Utilization Management (UM). An appropriate care statement is distributed to all employees, management staff and contracted physicians who deal with UM activities. To view the *Quality Improvement Program Description and Appropriate Care* statement, visit one of our websites, click *Corporate*, then *Quality Improvement Program*.

Companies	Case Management	Mental Health Case Management	Utilization Management
Medical Mutual®	800.258.3175	800.258.3186	800.338.4114
Consumers Life®	800.529.5697	800.233.2058	800.258.3035
Carolina Care Plan®	800.590.2583	800.877.6003	800.258.3021

### Who do I contact about medical care and treatment processes?

Our Care Management department is available to address your inquiries about Utilization Management issues, processes or requirements, such as inpatient admissions, denials, appeals and referrals (including behavioral mental health services and issues), Monday through Friday, excluding holidays, from 8:15 a.m. to 4:15 p.m. (Eastern). To speak with a Care Management

nurse or a mental health Case Manager, please call the number corresponding to your plan provider in the chart below left.

If you are scheduled for a hospital stay, once you have been admitted to the hospital, our Care Management nurse will work with the doctor to gather information about your condition. Care Management ensures that your physician's treatment recommendations are in line with national standards of care.

Certain services and medications require prior approval for medical necessity before the procedure or service is received. Some services are considered experimental/investigational and are not eligible for coverage. Prior approval is not a guarantee of payment; payment is subject to your benefits and contract provisions. Visit *My Health Plan* and click on *Support* to view the Prior Approval List.

If your doctor is in the network, he or she will be responsible for contacting our Care Management staff for prior approval. If the doctor is not in the network, you will need to obtain our prior approval in advance of treatment.

To speak with a Care Management nurse or a mental health Case Manager, please call the number corresponding to your plan provider in the chart on this page.

### How can I or my caregiver get help if I have a serious medical condition or a complex medical event?

Through our Case Management program, we have Registered Nurse Case Managers available to help you or your caregiver access resources and services, communicate with your healthcare team, and monitor your progress to ensure that services are appropriate and effective. Program participation is voluntary and addresses the healthcare options and needs of members who have complex illnesses or life-limiting or incurable conditions.

Case Management services are also available to help coordinate care, provide information

about community services in your area and provide education about your condition.

To speak with a Registered Nurse Case Manager Monday through Friday, excluding holidays, from 7:45 a.m. to 4 p.m. (Eastern), please call the number corresponding to your plan provider in the chart on page 4.

### **How do I obtain care and coverage when I am away from home?**

If you get sick or are in an accident while away from home, call the number on your ID card that is specific to locating a network doctor or hospital. If you need to be admitted to a hospital, call the prior approval number on your ID card for prior approval on your stay for medically necessary services. If it is a medical emergency, go to the nearest emergency room or, if necessary, call 911.

### **How can I set up an advance directive?**

An advance directive is a legal document used to tell doctors, hospital personnel, your family or your representative the type of care you would like to receive if you become unconscious or unable to communicate. There are three types of advance directives: Living Will, Healthcare Power of Attorney and Do Not Resuscitate (DNR) order. For more information, contact the National Hospice and Palliative Care Organization by phone at 800.658.8898, or by visiting nhpco.org. You may also locate a hospice or palliative care program in your state through the *Find a Provider* link on nhpco.org. We also urge you to discuss this matter with your doctor.

### **How do I submit a claim?**

Most network providers will submit a claim for you. However, if you go to a doctor, hospital or provider that does not have a contract with us, ask them to submit a claim for you on a standardized claim form. If the provider will not submit the claim for you, contact Customer Service for a claim form. Complete the claim form and attach an itemized bill that includes the diagnosis, procedure, date of service, charge, and



## How to Log on to My Health Plan

If you are not a *My Health Plan* user, visit our website (i.e., [MedMutual.com](http://MedMutual.com), [CarolinaCarePlan.com](http://CarolinaCarePlan.com), [ConsumersLife.com](http://ConsumersLife.com)) today to register.

Click on *Not a member? Register now* under *Log in to My Health Plan* on the right of the website's homepage. Then complete the Required Insurance Card Information and agree to the Terms and Conditions.

If you are not a member and would like to preview *My Health Plan*, click on *Preview My Health Plan* in the login box.

doctor's or facility's name and address. Submit the completed form to our office within the timeframe stated in your Certificate or Benefit Book.

*If you go to a doctor, hospital or provider that does not have a contract with us, ask them to submit a claim for you on a standardized claim form.*

If you go to a hospital or doctor outside the country, get a copy of all your medical records and an itemized bill. If needed, have your records and bills translated to English. Submit your claim forms, bills and medical records to the address listed on your ID card. Please remember that benefit coverage and limitations still apply. Refer to your Certificate or Benefit Book for details.

### **Where do I find a claim form?**

You can find medical, dental and vision claim forms on your plan's website, by logging on to *My Health Plan* or by calling Customer Service.

### **How can I obtain care after normal office hours?**

If you need prompt but not emergency medical attention, ask your doctor what to do or go to a network urgent care facility that can treat



your condition, which could lower your costs compared to the use of an emergency room.

Symptoms that may require urgent care include:

- Signs of the flu
- Signs of a sprain
- Signs of a sinus, ear or bladder infection



### What is an emergency?

In an emergency, symptoms are severe and serious enough that a person who has no medical training, with an average knowledge of health and medicine, could reasonably expect that, without immediate medical attention, the result would be any of the following:

- Placing the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any body part or organ

Examples of emergencies are shock, chest pain, choking, poisoning, unconsciousness, severe pain, uncontrolled bleeding, hallucinations, delusions and attempted harm to oneself or others.



## Do You Know How Healthy You Are?

When it comes to your health, find out where you stand. Take our online Health Assessment to learn how healthy you are overall and identify your risks for certain chronic diseases. Get tips and tools to help manage and improve your health.

Log on to *My Health Plan* and find the Health Assessment listed under *Assess My Health*. If you do not have access to a computer or the Internet, call Customer Service to obtain copies of this information.

To monitor for changes in your health status, make sure you complete the Health Assessment once a year.

### How do I obtain emergency care?

During a medical emergency, go to the nearest emergency room or, if necessary, call 911. Contact your doctor within 24 hours of the emergency to arrange follow-up care with a network provider. If you are admitted to a hospital, our Care Management department will work with your doctor to review your care.

### How can I ask a question or voice a complaint?

If you have a problem or concern, you can:

- Email Customer Service through our website by clicking on *Contact Us*
- Call Customer Service
- Mail a letter to your employer or benefit administrator or to Medical Mutual, 2060 East Ninth Street, Cleveland, Ohio 44115

When reviewing your complaint, we will follow the complaint procedure described in your Certificate or Benefit Book.

If you have trouble scheduling an appointment with a healthcare professional, you can:

- Complete the *Problem Scheduling an Appointment* form on *My Health Plan* in the *Forms* section
- Call Care Management (see chart on page 4)

### Can I file a complaint anywhere else?

If applicable to your health plan, you may contact your state's Department of Insurance. You can find the contact information on your state's website, under state agencies in your phone book or by calling Customer Service. If your complaint is about a denial, reduction or termination of a benefit or service and you continue to disagree with our decision, you have the right to file a complaint with the Department after all appeal rights have been exhausted.

Members of self-insured groups (other than a public employee benefit plan) should not file a complaint with the Department of Insurance. For information about how to file a complaint, contact your employer or group official, check your Certificate or Benefit Book, or contact the

U.S. Department of Labor Employee Benefits Security Administration ([dol.gov/ebsa](http://dol.gov/ebsa)).

### **How can I file an appeal if my claims, requested services or eligibility have been denied?**

Special Notice: The Patient Protection and Affordable Care Act (PPACA) enacted by the federal government in 2010 created new rules about appeals. These rules go into effect at different times for different plans. You will be notified of any changes affecting your plan as they take effect.

- If you are part of a self-funded labor union or other self-insured group, you should refer to your Benefit Book for how to file an appeal.
- All others may refer to the following appeal procedure.

Members may exercise their right to appeal a denial to pay a claim or approve a service or procedure according to the applicable laws of the state where your policy was sold and applicable federal law. There is no charge for filing an appeal.

Your appeal must be filed within 180 days from the date you received your original denial. Member appeal forms can be found on the *Forms* section of *My Health Plan* or by calling Customer Service. Instructions for completing the form, and the fax number and mailing address for submitting your appeal, are included on the form. To support your appeal, please send any records, doctor's office notes, photos, dental X-rays and/or radiology reports you would like considered in making a decision about your appeal.

An appeal request must come from the patient unless he or she is a minor (in which case a parent or legal guardian of the patient may file the appeal), has appointed an individual as power of attorney representing the patient, or has authorized an individual to act as his or her representative in these matters.

To appeal a denial to approve care you need right away, call Care Management or Mental

Health Case Management (see chart on page 4). Urgent care appeals will be decided within 72 hours, as will appeals for care you need while you are in the hospital. Our review and decision about all non-urgent appeals will be made within 30 days from the date of our receipt of your appeal request (or sooner according to the laws of your state). You will receive notice of our appeal decision in writing. If our original decision is not overturned you will be notified of any additional appeals rights you may have.

### **Could the Department of Insurance review my case if it is denied?**

Yes. If we deny a claim, do not approve a service or procedure, or reduce or terminate coverage for a healthcare service because it is not covered under the terms of your policy or Certificate, and the Department of Insurance has jurisdiction over your plan, you may have the option to submit an inquiry to the Department of Insurance in the state where your policy was sold.

You should first file your appeal with us. If your appeal has been heard and continues to be denied, you or an authorized representative (e.g., parent, guardian or individual authorized to make healthcare decisions on your behalf) may make a written request to the Department of Insurance to review the terms of your policy or Certificate and determine whether the healthcare service is a covered service. If the determination of coverage requires resolution of a medical issue, you will be notified so the medical issue may be properly reviewed.

### **How can I obtain an independent external review of my denied claim or request for a service or procedure?**

If applicable to your health plan, you may qualify for an external review by an Independent Review Organization (IRO) if the service you are appealing meets certain conditions set by applicable state or federal law. You must first exhaust the internal appeal process with us unless you are eligible to exercise your external review rights concurrently or immediately. You will be informed in writing of your external



review rights as part of our initial appeal decision. You will also be informed of the timeframe you have from the date of receipt of our initial appeal decision to request an external review.

IROs will decide urgent and non-urgent cases in the timeframes established by the applicable state or federal law and regulations. You will be advised in writing of the IRO's decision.



### What are my rights as an ERISA plan member?

For members of an Employee Retirement Income Security Act (ERISA) plan, the group administrator is required to administer the plan according to its written provisions. Members of an ERISA plan also have the right, under Section 502(a) of ERISA, to bring a civil action after a denial on appeal. Please contact your group administrator to learn if you are affected by ERISA or for more information. Any statute of limitations applicable to pursuing your claim in court will be suspended during the period of the additional voluntary appeal. If you decide

to proceed with a voluntary appeal, you do not need to exhaust this option prior to pursuing a claim in court.

### What are my rights as a member of a public entity (Schools and Government)?

Public entities are not subject to ERISA, so your rights and remedies are different from those available to an ERISA plan member. Please refer to your Benefit Book for more information.

### Do you provide assistance for the hearing or speech impaired, or for people who speak a language other than English?

If you have a special need or preference relating to the administration of your health plan or obtaining medical services, please call Customer Service (or TTY/TDD 800.982.8109 for the hearing and speech impaired). Callers who do not speak English will be connected by Customer Service to a language line interpretation service.

Language assistance is available to answer your questions and help you register an appeal or complaint. We offer bilingual telephone translation services, and can respond to your appeal or complaint in your primary language, if other than English, upon your request. To obtain language assistance, please call Customer Service and inform the Customer Service representative that language assistance is needed.



## Get the Most Out of Your Medical Benefits

### Before you use your health plan, here are five things to check:

**Check** that your doctor, hospital or other healthcare provider is in our network, even when you have been referred to the provider by an in-network physician.

**Check** your Certificate or Benefit Book for the services and procedures your benefits cover.

**Check** with Customer Service to determine if prior approval is needed before you have a procedure.

**Check** with your doctor about going to an urgent care facility rather than the emergency room if you have a medical problem that requires attention but is not life threatening.

**Check** with Customer Service or visit *My Health Plan* if you have questions.

# Rights & Responsibilities

## Member Rights & Responsibilities

As a member of Medical Mutual and its Family of Companies, you have certain rights and responsibilities. Being familiar with these rights and responsibilities will help you participate in your own healthcare. Please know as a Company we assure member rights and member responsibilities, which are defined as your role in working with us to achieve a high-quality, cost-effective health outcome.

### Member Rights

#### Information Disclosure

- You have the right to receive accurate, easy-to-understand information about your health plan and its services, healthcare providers, covered services, financial liability, health promotion, illness prevention, advance directives (e.g., Living Will, Healthcare Power of Attorney), and rights and responsibilities.
- You have the right to receive information about our Company. As applicable to your plan, you have the right to receive information about services provided on behalf of your employer or plan sponsor as well as our staff, and staff qualifications and any contractual relationships.
- You may choose to ask another person to help you or act on your behalf if you are unable to act alone at any step in the healthcare process.
- If English is not your primary language or if you have a disability or do not understand your health plan or healthcare, we can provide help so you can make informed healthcare decisions.

#### Choice of Providers

- You have the right to choose among healthcare providers, hospitals, pharmacies and other facilities within our network.
- You have the right to choose a primary care provider in our network who is accepting new enrollees.
- You have the right to see a specialist in our network without obtaining a referral from your primary care provider.

#### Coverage

- As a member of certain group health plans, you may have the right to receive covered services without the consideration of pre-existing conditions if you are younger than age 19. Check with your health plan administrator, insurer or employer to determine if your policy includes this member right.
- You have the right to not have your policy rescinded after it was active except in situations of fraud or intentional misrepresentation, according to federal and state laws and the terms of your policy.
- You have the right to receive certain essential health benefits covered by your health plan without restrictive annual dollar limits.
- You have the right to get covered services and prescriptions filled within a reasonable timeframe.
- You have the right to receive coverage for an ongoing course of treatment pending the outcome of an appeal of a coverage decision that reduces or terminates benefits for that course of treatment.
- For the services provided to you within the terms of your plan, your rights include prompt and accurate payment of your claim.
- You have the right to have your coverage decisions made by individuals who have expertise in the area of medicine in which your claim falls and by individuals who are impartial.

### **Access to Emergency Services**

- If you have severe pain, an injury or sudden illness that leads you to believe that your health is in serious jeopardy, you have the right to be screened and stabilized for emergency care in a facility that provides emergency care.
- When you are injured, experiencing severe pain, injury or sudden illness that leads you to believe your health is in serious jeopardy, you do not need our prior approval or authorization before seeking emergency care.
- When using emergency room services for emergency care, you are not required to see a network provider, and you will not be charged an out-of-network penalty for receiving emergency services for emergency care from an out-of-network provider.

### **Participation in Treatment Decisions and in Your Health Plan**

- You have the right to talk in confidence with your healthcare provider and to participate in making decisions about your care.
- You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to decline medical treatment or participation in a program we offer and to disenroll from services we offer.
- You have the right to make recommendations about this *Member Rights and Responsibilities* policy statement.

### **Respect and Nondiscrimination**

- You have the right to fair, considerate, courteous, respectful and nondiscriminatory care from your healthcare providers, our employees and plan representatives. You have the right to be treated with respect and recognition of your dignity and your right to privacy.
- You have the right to ask for assistance if you think you are treated unfairly or your rights are not respected.
- You are not required to waive rights to obtain benefits from your health plan.

### **Privacy and Confidentiality**

- You have the right to exercise all federal and state privileges that protect your personal and medical information and records. You can also exercise your privacy rights under the Health Information Portability and Accountability Act (HIPAA) without fear of retaliation or condition of payment.
- You have the right to privacy and confidentiality in the usage of your personal and medical information and records.
- You have the right to request that we place restrictions on the use and disclosure of your information. You have the right to authorize or deny release of your protected health information beyond its use for treatment, payment or healthcare operations.
- You have the right to access or receive a copy of your protected health information used and stored by us. For access to your entire medical record, you must contact the doctor or facility that provided the service.
- You have the right to request an amendment to your personal and medical information. We cannot amend information we did not create. We will refer you to the service provider if you request an amendment to your diagnosis or treatment information.
- You have a right to an accounting of certain disclosures of your information made by us and our business associates over the last six years.
- You have the right to complain if you believe your rights have been violated, including the right to complain to the Secretary of the U.S. Department of Health and Human Services.
- You have the right to receive a Notice of Privacy Practices describing our policies and procedures.
- You have the right to request that we communicate with you in confidence about your information at a location different from the address associated with your policy.

## Complaints and Appeals

- You have the right to voice complaints or appeals about us, the care provided or any quality issue.
- You have a right to communicate complaints to us and receive instructions on how to use the complaint process that includes our standards of timeliness for responding to and resolving complaints and quality issues.
- You have the right to request and receive, at no charge, copies of the information and documentation we considered or relied on to make a coverage decision.
- You have the right to file an appeal of a denial or reduction of a benefit or a claim because you were told it was not medically necessary, was experimental or investigational, was not a benefit of your health plan, or involved a pre-existing condition.
- You have the right to file an appeal if you were denied coverage because of ineligibility or your policy was rescinded after you became an active member.
- You have the right to get a fair, objective and timely review and resolution of an appeal; to be told how the appeal will be handled according to federal and state laws; and to be told any important time limits related to filing your appeal.
- If you are covered by a fully insured program, you have the right to request a review of a denied service or benefit by the department of insurance (DOI) of your state. A review by your state's DOI may be available if we deny, reduce or discontinue coverage for a service you were told is not covered, not medically necessary or is experimental or investigational.
- Once you have exhausted your internal appeals, you may have the right to an external review by an Independent Review Organization (IRO). This right may exist if we deny, reduce or discontinue coverage for a service on the basis of medical necessity, appropriateness of care, healthcare setting, level of care, effectiveness of a covered benefit, or an experimental or investigational determination. This right depends on the type

of health plan you have. You should review your Certificate or Benefit Book, or contact us or your health plan administrator to find out if this right and the process for pursuing this right applies to your health plan.

## Member Responsibilities

- When speaking with us or your provider, supply all the information needed to provide care.
- When speaking with us or your provider, understand your health problems and participate in developing a mutually agreed-upon treatment plan and goals that work for you and your healthcare provider, to the degree possible.
- When speaking with us or your provider, follow the agreed-upon plan and instructions for care.
- Choose a primary care provider who is available to accept new enrollees and to coordinate medical services if required or advised by your plan.
- Take responsibility for improving or maintaining your healthy lifestyle habits including exercising, not smoking, controlling stress, eating a healthy diet, drinking alcohol only in moderation and following safety guidelines.
- Learn how to voice a complaint and file an appeal.
- Learn about your coverage options, limitations and exclusions by reviewing the resources available to you.
- Know the rules regarding use of network providers, coverage and prior approval according to your plan.
- Know how to get information from your health plan's website, customer service and/or your health plan administrator.
- Meet your financial obligations to the healthcare providers who treat you.
- Report to us suspected wrongdoing and fraud.
- Be a responsible consumer of healthcare resources available to you.



### **What does the Company do to protect my right to privacy?**

We have strict policies and procedures to protect your personal information, including data on your healthcare that is stored on our computer systems. You can view our Privacy Notice on our websites for more information on the collection, use and disclosure of members' protected health information (PHI), and how to authorize or deny the release of PHI beyond uses for treatment, payment or healthcare processes.

### **How do I exercise privacy rights?**

Visit your plan's website or our websites to find information about privacy rights. Look for *HIPAA* then click *Privacy and Confidentiality Notice*, or call Customer Service.

### **What should I do if I believe my rights have been violated?**

If you feel your rights have been violated, call Customer Service at the number on your ID card.

**Para la ayuda de interpretación de lenguaje por favor póngase en (contacto) con el Servicio de Cliente al número localizado en su tarjeta de identificación.**

**If you do not have access to the Internet or prefer to have information explained or provided in a written format, please call Customer Service.**

---

The information provided, including the websites and any links, is for your information only. It does not take the place of, nor is it intended to substitute for, professional medical advice, diagnosis or treatment from your doctor. The information does not establish or imply coverage for any particular treatment or service. The recommended services may not be covered. Eligibility and coverage depend upon the specific terms and conditions of your benefit plan.

---



**large network** of  
doctors and hospitals

# helping members



**get the care they need**

**high-quality**  
healthcare

wide range of



**health programs**





**MEDICAL MUTUAL®**

2060 East Ninth Street  
Cleveland, OH 44115-1355

© 2011 Medical Mutual of Ohio  
Z7067 R9/11

[CarolinaCarePlan.com](http://CarolinaCarePlan.com)

[MedMutual.com](http://MedMutual.com)

[ConsumersLife.com](http://ConsumersLife.com)

**K E E P   T H I S   D O C U M E N T   F O R   Y O U R   R E C O R D S**