Instructions to Health Plans

* [*Plans can add a cover page to the Summary of Benefits. Plans can include the Material ID only on the cover page.*]
* [*Plans can change the orientation of the document from landscape to portrait.*]
* [*Where the template instructs inclusion of a phone number, plans must ensure it’s a toll-free number and include a toll-free TTY number and days and hours of operation. Plans must provide one phone number for both Medicare and Medicaid covered services if they’re separate.*]
* [*Plans should add or delete the categories in the “Services you may need” column to match state-specific benefit requirements.*]
* [*For the “Limitations, exceptions, & benefit information” column, plans should provide specific information about need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out-of-pocket costs on services, permissible out-of-network (OON) services, and applicable cost sharing (if different than in-plan cost sharing).*]
* [*Plans can place a QR code on materials to provide an option for members to go online.*]
* [*Wherever possible, plans are encouraged to adopt formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
* *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes the Table of Contents or any item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, insert: This section is continued on the next page).*
* *Ensure plan-customized text is in plain language and complies with member reading level requirements.*
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
* *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term Services and Supports (LTSS) or low income subsidy (LIS)).*
* *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
* *Avoid separating a heading or subheading from the text that follows when paginating the model.*
* *Use universal symbols or commonly understood pictorials.*
* *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
* *Consider using regionally appropriate terms or common dialects in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*]

Introduction

This document is a brief summary of the benefits and services covered by <plan name>. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of <plan name>. Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage*.

[*After adding plan-customized information, plans must update the Table of Contents as needed to reflect the correct page number where each section begins.*]

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# Disclaimers

This is a summary of health services covered by <plan name> for <date>. This is only a summary. Please read the *Evidence of Coverage* for the full list of benefits. [*Plans must include information about how to contact Member Services to get an Evidence of Coverage and how to access the Evidence of Coverage on the plan’s website.*]

* [*Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V) and included in any state-specific guidance provided by Med-QUEST Division.*]
* [*As required at 42 CFR § 438.10(d)(2), all disclaimers and taglines that explain the availability of alternate formats using auxiliary aids and services or oral interpretation services and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a), must be in a conspicuously visible font.*]
* For more information about Medicare, you can read the *Medicare & You* handbook. It has a summary of Medicare benefits, rights, and protections and answers to the most frequently asked questions about Medicare. You can get it at the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
* For more information about <plan name>, you can check the Med-QUEST Division’s website [medquest.hawaii.gov/en/members-applicants/Dual-Eligible-Special-Needs-Plan](https://medquest.hawaii.gov/en/members-applicants/Dual-Eligible-Special-Needs-Plan.html) or contact the Med-QUEST Division’s Office of the Ombudsman at 1-888-488-7988 toll-free , 711 TTY, Monday through Friday 7:45am – 4:30pm (excluding State holidays).
* [*Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that, at a minimum, states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in Hawaii and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.*]
* You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.
* [*Plans that meet the Medicare 5 percent alternative language threshold per 42 CFR §§ 422.2267(a) and 423.2267(a)* *or Medicaid required language threshold insert:* This document is available for free in <languages that meet the threshold.>]
* [*Plans also must simply describe:*
* *how they’ll request a member’s preferred language other than English and/or alternate format,*
* *how they’ll keep the member’s information as a standing request for future mailings and communications so the member doesn’t need to make a separate request each time, and*
* *how a member can change a standing request for preferred language and/or format.*]

# Frequently asked questions (FAQ)

The following table lists frequently asked questions. [*Plans should add text in bold at the end of a frequently asked question (FAQ) title if the service continues onto the next page:* **(continued on the next page)**. *Plans should add text in bold after the FAQ title on the following page:* **<FAQ>** **(continued from previous page)**. *Plans should also be aware that the flow of FAQ from one page to the next can vary after plan-customized information is added, which can necessitate adding and/or removing these instructions in other FAQ as needed. Additionally, plans should maintain consistency of table formatting, borders, and color scheme throughout after adding plan-customized information.*]

[*Plans can add a maximum of two additional FAQs to this section. For example, plans can add an FAQ giving additional information about their specific plan or describing their model of care. Answers must be kept brief, consistent with the pre-populated responses in the template.*]

| **Frequently Asked Questions** | **Answers** |
| --- | --- |
| **What’s an integrated D-SNP?** | An integrated D-SNP is a health plan that contracts with both Medicare and Med-QUEST Division to provide Medicare and Medicaid services to enrollees. An integrated D-SNP combines your doctors, hospital, pharmacies, home care, nursing home care, and other health care providers into one coordinated care system. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need. |
| **Will I get the same Medicare and Medicaidbenefits in <plan name> that I get now?** | You’ll get most of your covered Medicare and Medicaid benefits directly from <plan name>. You’ll work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change based on your needs, and your doctor and care team assessment. You may also get other benefits outside of your health plan the same way you do now, directly from Community Care Services (CCS) or through Hawaii’s Department of Health’s Developmental Disabilities Division (DDD), Adult Mental Health Division (AMHD) and Child and Adolescent Mental Health Division (CAMHD), if applicable.  When you enroll in <plan name>, you and your care team will work together to develop [*plans insert term used, such as:* an Individualized Plan of Care *or* a care plan] to address your health and support needs, reflecting your personal preferences and goals.  If you’re taking any Medicare Part D drugs that <plan name> doesn’t normally cover, you can get a temporary supply and we’ll help you to transition to another drug or get an exception for <plan name> to cover your drug if medically necessary. For more information, call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> or at the numbers listed at the bottom of this page or at the numbers in the footer of this document]. |
| **Can I use the same doctors I use now? (continued on next page)** | This is often the case. If your providers (including doctors, hospitals, therapists, pharmacies, and other health care providers) work with <plan name> and have a contract with us, you can keep going to them.   * Providers with an agreement with us are “in-network.” Network providers participate in our plan. That means they accept members of our plan and provide services our plan covers. **You must use the providers in <plan name>’s network.** If you use providers or pharmacies that aren’t in our network, the plan may not pay for these services or drugs. |
| **Can I use the same doctors I use now? (continued from previous page)** | * If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of <plan name>’s plan. [*Plans can insert additional exceptions as appropriate.*] * If you’re currently under treatment with a provider that’s out of <plan name>’s network, or have an established relationship with a provider that’s out of <plan name>’s network, call Member Services to check about staying connected*.*   To find out if your providers are in the plan’s network, call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or read <plan name>’s [*insert either Provider and Pharmacy Directory* *or Provider Directory*] on the plan’s website at <URL>. [*Plans can insert additional language regarding the possibility for member’s out-of-network providers to contract with the plan.*]  If <plan name> is new for you, we’ll work with you to develop [*plans insert term used, such as:* an Individualized Plan of Care *or* a care plan] to address your needs. |
| **What’s a <plan name> care coordinator?** | A <plan name> care coordinator is one main person for you to contact. This person helps to manage all your providers and services and make sure you get what you need, including the following:   * [*Insert information to provide more detail about plan’s care coordination requirements and supports, including information on how members can contact their care coordinator.*] |
| **What are Long-term Services and Supports (LTSS)?** | Long-term Services and Supports are help for people who need assistance to do everyday tasks like bathing, toileting, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. |
| **What happens if I need a service but no one in <plan name>’s network can provide it?** | Most services will be provided by our network providers. If you need a service that can’t be provided within our network, <plan name> will pay for the cost of an out-of-network provider. |
| **Where’s <plan name> available?** | The service area for this plan includes: <County name(s)> [*plans insert:* County***or*** Counties], <State>. You must live in [*plans should enter:* this area ***or*** one of these areas] to join the plan.  [*Plans enter if applicable:* \* Denotes partial county.Call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] for more information about whether the plan is available where you live.] |
| **What’s prior authorization? (continued on next page)** | Prior authorization means an approval from <plan name> to seek services outside of our network or to get services not routinely covered by our network **before** you get the services. <Plan name> may not cover the service, procedure, item, or drug if you don’t get prior authorization.  **If you** **need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first**. <Plan name> can provide you or your provider with a list of services or procedures that require you to get prior authorization from <plan name> before the service is provided. |
| **What’s prior authorization? (continued from previous page)** | Refer to **Chapter 3**, [*plans can insert reference, as applicable*] of the *Evidence of Coverage* to learn more about prior authorization. Refer to the Benefits Chart in **Chapter 4** of the *Evidence of Coverage* [*plans can insert reference, as applicable*] to learn which services require a prior authorization.  If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] for help. |
| **What’s a referral?**  [*If a plan doesn’t require referrals for any of its services, the plan can delete this question.*] | A referral means that your [*insert:* primary care provider (PCP) ***or*** care team] must give you approval to go to someone that isn’t your PCP. A referral is different than a prior authorization. If you don’t get a referral from your [*insert:* PCP ***or*** care team], <plan name> may not cover the services. <Plan name>can provide you with a list of services that require you to get a referral from your [*insert:* PCP ***or*** care team] before the service is provided.  Refer to the *Evidence of Coverage* [*plans can insert section reference, as applicable*] to learn more about when you’ll need to get a referral from your [*insert:* PCP *or* care team]. |
| **Do I pay a monthly amount (also called a premium) under <plan name>?** | No. Because you have Medicaid you won’t pay any monthly premiums, including your Medicare Part B premium, for your health coverage. |
| **Do I pay a deductible as a member of <plan name>?** | No. You don’t pay deductibles in <plan name>. |
| **What‘s the maximum out-of-pocket amount that I’ll pay for medical services as a member of <plan name>?** | There‘s no cost sharing for medical services in <plan name>, so your annual out-of-pocket costs will be $0. |

# List of covered services

The following table is a quick overview of what services you may need, your costs, and rules about the benefits. [*Plans should list the following text under a health need or concern title if its services continue on the next page*: **(continued on the next page)**. *Plans should also enter the health need or concern title with* **(continued)***below the title at the top of the following page*. *When adding or deleting health needs or concerns or services or when populating the chart in this section, plans should maintain consistency of formatting, borders, and color scheme throughout. The chart is properly formatted in the model to serve as an example for plans.*]

| **Health need or concern** | **Services you may need** [*This category includes examples of services that members may need. The health plan should add or delete any services based on the services covered by the plan under Medicare and Medicaid.*] | **Your costs for in-network providers** | **Limitations, exceptions, & benefit information (rules about benefits)** [*Plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out-of-pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-network cost sharing).*] |
| --- | --- | --- | --- |
| **You need hospital care** | Inpatient hospital stay | [$0] | [*Insert or modify as applicable:* Except in an emergency, your health care provider must tell the plan of your hospital admission.] |
| Outpatient hospital services, including observation | [$0] |  |
| Ambulatory surgical center (ASC) services | [$0] |  |
| Doctor or surgeon care | [$0] |  |
| **You want a doctor** | Visits to treat an injury or illness | [$0] |  |
| Care to keep you from getting sick, such as flu shots and screenings to check for cancer | [$0] |  |
| Wellness visits, such as a physical | [$0] |  |
| “Welcome to Medicare” (preventive visit one time only) | [$0] |  |
| Specialist care | [$0] |  |
| **You need emergency care** | Emergency room services | [$0] | [*Plans must state that emergency room services must be provided OON and without prior authorization requirements.*] |
| Urgent care | [$0] | [*Plans must state that urgent care services must be provided OON and without prior authorization requirements.*] |
| **You need medical tests (continued on the next page)** | Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs) | [$0] |  |
| **You need medical tests (continued from previous page)** | Lab tests and diagnostic procedures, such as blood work | [$0] |  |
| **You need hearing/auditory services** | Hearing screenings | [$0] |  |
| Hearing aids | [$0] |  |
| **You need dental care** | Dental check-ups and preventive care | [$0] | [*Plans must include link to information about Medicaid dental benefits and providers as applicable*] |
| Restorative and emergency dental care | [$0] | [*Plans must include link to information about Medicaid dental benefits and providers as applicable*] |
| **You need eye care** | Eye exams | [$0] |  |
| Glasses or contact lenses | [$0] |  |
| Other vision care | [$0] |  |
| **You need behavioral health services** | Behavioral health services | [$0] | For specialized behavioral health services, see Community Care Services (CCS) in **Section D**. CCS provides specialized behavioral health services to eligible adult Medicaid members with severe mental illness (SMI) and/or severe and persistent mental illness (SPMI). |
| Inpatient and outpatient care and community-based services for people who need behavioral health services | [$0] | For specialized behavioral health services, see Community Care Services (CCS) in **Section D**. CCS provides specialized behavioral health services to eligible adult Medicaid members with severe mental illness (SMI) and/or severe and persistent mental illness (SPMI). |
| **You need substance use disorder services** | Substance use disorder services | [$0] |  |
| **You need a place to live with people available to help you** | Skilled nursing care | [$0] |  |
| Nursing home care | [$0] |  |
| Adult Foster Care and Group Adult Foster Care | [$0] |  |
| **You need therapy after a stroke or accident** | Occupational, physical, or speech therapy | [$0] |  |
| **You need help getting to health services** | Ambulance services | [$0] |  |
| Emergency transportation | [$0] |  |
| Transportation to medical appointments and services | [$0] |  |
| **You need drugs to treat your illness or condition (continued on the next page)** | Medicare Part B drugs | [$0] | Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Evidence of Coverage* for more information on these drugs. |
| **You need drugs to treat your illness or condition (continued)** | Medicare Part D drugs  [*Plans should insert tiers and a description of each tier. For example:*  Tier 1: Preferred Generic  Tier 2: Generic  Tier 3: Brand  Tier 4: Specialty] | [*Plans should insert a single amount or all applicable copay amounts for a tier with LIS copay amounts*] for a [*must be at least 30-day*] supply.  [*Plans can delete the following statement if they charge $0 for all drugs.*]  Copays for drugs may vary based on the level of Extra Help you get. Please contact the plan for more details. | There may be limitations on the types of drugs covered. Please refer to <plan name>’s *List of Covered Drugs* (*Drug List*) for more information.  [*Plans can delete the following statement if they only have one coverage stage.*] Once you or others on your behalf pay <insert TrOOP amount> you’ve reached the catastrophic coverage stage and you pay $0 for all your Medicare drugs. Read the *Evidence of Coverage* for more information on this stage.  [*Cost sharing must be broken down by the tier number/name (e.g. Tier 1: Preferred Generic)*.]  [*Plans must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations and make clear that the cost sharing amount for these extended-day supplies is the same as for a one-month supply.*] |
| **You need drugs to treat your illness or condition (continued)** | [*Plans insert as applicable:* Over-the-counter (OTC) drugs] | [*Plans should insert a single amount, multiple amounts, or minimum/maximum range*.] | There may be limitations on the types of drugs covered. Please refer to <plan name>’s *List of Covered Drugs* (*Drug List*) for more information. |
| **You need help getting better or have special health needs** | Rehabilitation services | [$0] |  |
| Medical equipment for home care | [$0] |  |
| Dialysis services | [$0] |  |
| **You need foot care** | Podiatry services | [$0] |  |
| Orthotic services | [$0] |  |
| **You need durable medical equipment (DME) (continued on the next page)** | Wheelchairs, crutches, and walkers | [$0] |  |
| Nebulizers | [$0] |  |
| **You need durable medical equipment (DME) (continued from previous page)**  **Note:** This isn’t a complete list of covered DME. For a complete list, contact Member Services or refer to **Chapter 4** of the *Evidence of Coverage*. | Oxygen equipment and supplies | [$0] |  |
| **You need help living at home (continued on the next page)** | Home health services | [$0] | [*Plans should include information about how to get Medicaid Community Supports like home modifications.*] |
| Home maintenance such as grab bars and ramps | [$0] | [*Plans should include information about how to get Medicaid Community Supports like home modifications.*] |
| **You need help living at home (continued from previous page)** | Adult day health, adult day care, or other support services | [$0] | [*Plans should include information on how to qualify for these or similar support services available.*] |
| Home delivered meals | [$0] | [*Plans should include information about how to get Medicaid Community Supports like home modifications.*] |
| Personal care attendant services | [$0] | [*Update as applicable: Plans should include information about Home Health as well as reference info below about Medicaid Community Supports.*] |
| **Additional services** [*Plans are encouraged to insert other special services they offer that aren’t already included in the chart. This doesn’t need to be a comprehensive list.*] | Chiropractic services | [$0] |  |
| Diabetes supplies and services | [$0] |  |
| Prosthetic services | [$0] |  |
| Radiation therapy | [$0] |  |
| Services to help manage your disease | [$0] |  |

The above summary of benefits is provided for informational purposes only and isn’t a complete list of benefits. For a complete list and more information about your benefits, you can read the <plan name> *Evidence of Coverage*. If you don’t have an *Evidence of Coverage*, call <plan name> Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] to get one. If you have questions, you can also call Member Services or visit <URL>.

# Benefits covered outside of <plan name>

There are some services that you can get that aren’t covered by <plan name> but are covered by Medicare, Medicaid, or a State or county agency. This isn’t a complete list. Call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] to find out about these services.

| **Other services covered by Medicare, Medicaid, or a State Agency** | **Your costs** |
| --- | --- |
| [*Insert services covered outside the plan by Medicare fee-for-service and/or Medicaid fee-for-service, as appropriate. This doesn’t need to be a comprehensive list, but at a minimum should include the following items.*] | [*Plans should include copays for listed services.*] |
| Dental services |  |
| Intellectual and developmental disabilities home and community-based services Medicaid waiver program (Hawaii’s Department of Health’s Developmental Disabilities Division) |  |
| State of Hawaii Organ and Tissue Transplant (SHOTT) |  |
| Certain hospice care services covered outside of <plan name> | $0 |
| Specialized behavioral health services by the Community Care Services (CCS) Program  Specialized behavioral health services are provided by the Community Care Services (CCS) program. This program provides intensive behavioral health services, in addition to basic behavioral health services covered by Medicaid health plans, to adults diagnosed with a qualifying serious mental illness (SMI) and/or a serious and persistent mental illness (SPMI). These adults must be enrolled in a Medicaid health plan and meet CCS eligibility criteria as determined by Med-QUEST Division (MDQ). |  |

# Services that <plan name>, Medicare, and Medicaid don’t cover

This isn’t a complete list. Call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] to find out about other excluded services.

| **Services <plan name>, Medicare, and Medicaid don’t cover** | |
| --- | --- |
| [*Insert any excluded benefit categories. This doesn’t need to be a comprehensive list. Plans can consult* ***Chapter 4*** *of the Evidence of Coverage for examples.*] |  |
| Services not considered “reasonable and necessary” according to standards of Medicare and Medical Assistance |  |

# Your rights as a member of the plan

As a member of <plan name>, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We’ll tell you about your rights at least once a year. For more information on your rights, please read the *Evidence of Coverage*. Your rights include, but aren’t limited to, the following:

**You have a right to respect, fairness, and dignity.** This includes the right to:

* Get covered services without concern about medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance
* Get information in other languages and formats (for example, large print, braille, or audio) free of charge
* Be free from any form of physical restraint or seclusion

**You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a language and format you can understand. This includes the right to get information on:

* Description of the services we cover
* How to get services
* How much services will cost you
* Names of health care providers and care coordinator

**You have the right to make decisions about your care, including refusing treatment.** This includes the right to:

* Choose a primary care provider (PCP) and change your PCP at any time during the year
* Use a women’s health care provider without a referral
* Get your covered services and drugs quickly
* Know about all treatment options, no matter what they cost or whether they’re covered
* Refuse treatment, even if your health care provider advises against it
* Stop taking medicine, even if your health care provider advises against it
* Ask for a second opinion. <Plan name> will pay for the cost of your second opinion visit
* Make your health care wishes known in an advance directive

**You have the right to timely access to care that doesn’t have any communication or physical access barriers.** This includes the right to:

* Get timely medical care
* Get in and out of a health care provider’s office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
* Have interpreters to help with communication with your health care providers and your health plan

**You have the right to seek emergency and urgent care when you need it.** This means you have the right to:

* Get emergency services without prior authorization in an emergency
* Use an out-of-network urgent or emergency care provider, when necessary

**You have a right to confidentiality and privacy.** This includes the right to:

* Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
* Have your personal health information kept private
* Have privacy during treatment

**You have the right to make complaints about your covered services or care.** This includes the right to:

* File a complaint or grievance against us or our providers
* File a complaint with <insert plan name> at <toll-free phone and TTY numbers>. The <insert plan name> website <URL> [*plans insert as applicable or adjust as needed:* has complaint forms, Independent Medical Review (IMR) application forms, and instructions available online.]
* [*Plans insert as applicable:* Ask for an IMR of Medicaid services or items that are medical in nature]
* Appeal certain decisions made by <plan name>
* Ask for a State Administrative Hearing for appeals not resolved wholly in your favor
* Get a detailed reason for why services were denied

For more information about your rights, you can read the *Evidence of Coverage*. If you have questions, you can call <plan name> Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

# How to file a complaint or appeal a denied service

If you have a complaint or think <plan name> should cover something we denied, call Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document]. You may be able to appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of the *Evidence of Coverage*. You can also call <plan name> Member Services [*plans can insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

[*Plans should include plan contact information for complaints, grievances, appeals, as well as the Med-QUEST Division’s complaint process.*]

# What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

Call us at <plan name> Member Services. Phone numbers are [*plans can insert reference:* on the cover of this summary *or* <toll-free phone and TTY numbers> *or* the numbers listed at the bottom of this page *or* the numbers in the footer of this document].

Or, call the Medicaid Customer Service Center at <toll-free number>. TTY users may call <toll-free number>.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free.

[*This is the recommended format for the back cover of the Summary of Benefits. Plans can add a logo and/or photographs, as long as these elements don’t make it difficult for members to find and read the contact information.* *Plans can modify the call lines as appropriate.*]

|  |
| --- |
| **If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call <plan name> Member Services:** |
| *<*toll-free phone number(s)>  Calls to this number are free. <days and hours of operation, including information on the use of alternative technologies>.  Member Services also has free language interpreter services available for non-English speakers. |
| *<*TTY number*>*  [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]  Calls to this number are free. *<*days and hours of operation*>.* |
| [*Insert if applicable:* **If you have questions about your health:**   * Call your primary care provider (PCP). Follow your PCP’s instructions for getting care when the office is closed. * If your PCP’s office is closed, you can also call <plan’s Nurse Line Name>. A nurse will listen to your problem and tell you how to get care. (*Example:* [convenience care,] urgent care, emergency room). The numbers for the <plan’s Nurse Line Name> are: |
| <phone number(s)>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies.*]  <Plan name> also has free language interpreter services available for non-English speakers. |
| *<*TTY number>  Calls to this number are [*Insert if applicable:* not] free. <Days and hours of operation.>] |
| [*Insert if applicable:* **If** **you need immediate behavioral health care, please call the <Behavioral Health Crisis Line name>:** |
| *<*phone number(s)>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies.*]  <Plan name> also has free language interpreter services available for non-English speakers. |
| *<*TTY number*>*  Calls to this number are [*Insert if applicable:* not] free. <Days and hours of operation.>] |