**Instructions to Health Plans**

* [Plans must revise references to “Medicaid” to use Michigan Medicaid, the state-specific name for the program throughout the handbook.]
* [Plans may add a cover page to the Summary of Benefits. Plans may include the marketing ID only on the cover page.]
* [*Plans should replace the reference to “Member Services” with the term the plan uses.*]
* [*Plans should note that any reference to a “Member Handbook” is also a reference to the Evidence of Coverage document.*]
* [*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 and permissible OON services.]*
* [*For the “You need help living at home” category of services, indicate if services are only available to beneficiaries in a waiver program, in which case plans should indicate that State eligibility requirements may apply.*]
* [*The multi-language insert is a document that contains language translated into multiple languages (Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese) regarding the availability of interpreter services. Regardless of the CMS or State translation requirements, all plans must include the CMS created multi-language insert as specified in the Medicare Marketing Guidelines.*]
* [*Plans may place a QR code on materials to provide an option for members to go online.*]

**This is a summary of health services covered by <plan name> for <date>. This is only a summary. Please read the Member Handbook for the full list of benefits.**

* <Plan’s legal or marketing name> is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees. It is for people with both Medicare and Medicaid.
* Under <plan name> you can get your Medicare and Medicaid services in one health plan. A Care Coordinator will help manage your health care needs.
* This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Member Handbook.
* Limitations, restrictions, and patient pay amounts may apply. This means that you may have to pay for some services and that you need to follow certain rules to have <plan name> pay for your services. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook.
* Benefits, List of Covered Drugs, and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year. Please contact the plan for more details.
* You can ask for this information in other formats, such as Braille or large print. Call <toll-free number>. The call is free.
* You can speak with someone about getting this information in other languages. Call <toll-free number>. The call is free. [*The preceding sentence must be in English, Arabic and Spanish. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]



**The following chart lists frequently asked questions.**

| **Frequently Asked Questions (FAQ)** | **Answers** |
| --- | --- |
| **What is a Medicare-Medicaid Plan?** | A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need. |
| **What is a <plan name> care coordinator?** | A <plan name> Care Coordinator is one main person for you to contact. This person helps manage all your providers and services and makes sure you get what you need. |
| **What are long term supports and services?** | Long term supports and services are help for people who need assistance to do everyday tasks like taking a bath, 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. |
| **Will you get the same Medicare and Medicaid benefits in <plan name> that you get now?** | You will get your covered Medicare and Medicaid benefits directly from <plan name>. You will 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. If you are currently receiving services for mental health, substance use, or intellectual/developmental disability needs, you will continue to receive these services the same way you do now.  When you enroll in <plan name>, you and your care team will work together to develop an Individual Integrated Care and Supports Plan (IICSP) to address your health and support needs. You can keep seeing your doctors and getting your current services for up to 90 days, or 180 days depending on the service, while your IISCP is being completed. When you join our plan, if you are taking any Medicare Part D prescription drugs that <plan name> does not normally cover, you can get a temporary supply. We will help you get another drug or get an exception for <plan name> to cover your drug, if medically necessary. |
| **Can you go to the same doctors you see now?** | Often that is the case. If your providers (including doctors, therapists, and pharmacies) 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.” You must use the providers in <plan name>’s network. If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of <plan name>'s plan. [*Plans may insert additional exceptions as appropriate.*]  To find out if your doctors are in the plan’s network, call Member Services or read <plan name>’s Provider and Pharmacy Directory.  If <plan name> is new for you, you can continue seeing the doctors you go to now while your IICSP is being developed. |
| **What happens if you 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 cannot be provided within our network, <plan name> will pay for the cost of an out-of-network provider. |
| **Where is <plan name> available?** | The service area for this plan includes: [*Plans should enter* county ***or*** counties] Counties [*plans should enter \* to denote partial county*], <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] |
| **Do you pay a monthly amount (also called a premium) under <plan name>?** | You will not pay any monthly premiums to <plan name> for your health coverage. |
| **What is prior authorization?** | Prior authorization means that you must get approval from <plan name> before you can get a specific service or drug or see an out-of-network provider. <Plan name> may not cover the service or drug if you don’t get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first. |
| **What is a referral?** | A referral means that your primary care provider must give you approval to see someone that is not your primary care provider. If you don’t get approval, <plan name> may not cover the services. There are certain specialists in which you do not need a referral, such as women’s health specialists. For more information on when a referral is necessary, see the Member Handbook. |
| **Who should you contact if you have questions or need help?** [*Plans may modify the call-lines as appropriate*] | **If you have general questions or questions about our plan, services, billing, or member cards, please call <plan name> Member Services:**   |  |  | | --- | --- | | **CALL** | <Phone number(s)>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies*.]  Member Services also has free language interpreter services available for people who do not speak English. | | **TTY** | <TTY/TDD phone number>  [*Insert if the plan uses a direct TTY number*: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.]  Calls to this number are [*Insert if applicable*: not] free. <Days and hours of operation.> | |
| **Who should you contact if you have questions or need help? (continued)** [*Plans may modify the call-lines as appropriate*] | **If you have questions about your health, please call the 24 Hour Nurse Advice line:**   |  |  | | --- | --- | | **CALL** | <Phone number>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies*.] | | **TTY** | <TTY/TDD phone number>  [*Insert if the plan uses a direct TTY number*: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.]  Calls to this number are [*Insert if applicable*: not] free. <Days and hours of operation.> |   [*Insert if applicable:* **If you need immediate behavioral health services, please call the Behavioral Health Crisis Line for the local Pre-paid Inpatient Health Plan (PIHP):** [*insert phone number for PIHP crisis line*].   |  |  | | --- | --- | | **CALL** | <Phone number>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies*.] | | **TTY** | <TTY/TDD phone number>  [*Insert if the plan uses a direct TTY number*: This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.]  Calls to this number are [*Insert if applicable*: not] free. <Days and hours of operation.>] | |

The following chart is a quick overview of what services you may need, your costs and rules about the benefits.

| **Health need or problem** | | | **Services you may need** [*This category includes examples of services that beneficiaries may need. The health plan should add or delete any services based on the services covered by the State.*] | | **Your costs for  in-network providers** [*Plans should insert cost sharing where applicable.*] | | **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). Plans may remove limitations or services if they are being covered by the plan as a flexible benefit.*] | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **You want to see a doctor** | | | Visits to treat an injury or illness | | $0 | |  | |
| Wellness visits, such as a physical | | $0 | |  | |
| Transportation to a doctor’s office | | $0 | |  | |
| Specialist care | | $0 | |  | |
| Care to keep you from getting sick, such as flu shots | | $0 | |  | |
| “Welcome to Medicare” preventive visit (one time only) | | $0 | |  | |
| **You need medical tests** | | | Lab tests, such as blood work | | $0 | |  | |
| X-rays or other pictures, such as  CAT scans | | $0 | |  | |
| Screening tests, such as tests to check for cancer | | $0 | |  | |
| **You need drugs to treat your illness or condition** | | | Generic drugs (no brand name) | | $0 copay [for a [*must be at least 30-day*] supply. | | There may be limitations on the types of drugs covered. Please see <plan name>’s List of Covered Drugs (Drug List) for more information.  [*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.*] | |
| Brand name drugs | | $0 copay [for a [*must be at least 30-*day] supply. | | There may be limitations on the types of drugs covered. Please see <plan name>’s List of Covered Drugs (Drug List) for more information.  [*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.*] | |
| Over-the-counter drugs | | $0 | | There may be limitations on the types of drugs covered. Please see <plan name>’s List of Covered Drugs (Drug List) for more information. | |
| Medicare Part B prescription drugs | | $0 | | Part B drugs include drugs given by your doctor in his or her office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the Member Handbook for more information on these drugs*.* | |
| **You need therapy after a stroke or accident** | | | Occupational, physical, or speech therapy | | $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.*] | | |
| Ambulance services | | $0 | |  | | |
| Urgent care | | $0 | | [*Plans must state that urgent care services must be provided OON and without prior authorization requirements.*] | | |
| **You need hospital care** | | Hospital stay | | $0 | |  | | |
| Doctor or surgeon care | | $0 | |  | | |
| **You need help getting better or have special health needs** | | | Rehabilitation services | | $0 | |  | |
| Medical equipment for home care | | $0 | |  | |
| Skilled nursing care | | $0 | |  | |
| **You need eye care** | | | Eye exams | | $0 | |  | |
| Glasses | | $0 | |  | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **You need dental care** | | | Dental check-ups, exams, x-rays, cleanings, fillings, tooth extractions, dentures and partial dentures | | $0 | | | Root canals and crowns are not covered.) | | |
| **You need hearing/auditory services** | | | Hearing screenings | | $0 | | |  | | |
| Hearing aids | | $0 | | |  | | |
| **You have a chronic condition, such as diabetes or heart disease** | | | Services to help manage your disease | | $0 | | |  | | |
| Diabetes supplies and services | | $0 | | |  | | |
| **You have a mental health condition** | | | Behavioral health services | | $0 | | | Provided through the Pre-paid Inpatient Health Plan (PIHP) | | |
| **You have concerns related to substance use** | | | Substance use services | | $0 | | | Provided through the Pre-paid Inpatient Health Plan (PIHP) | | |
| **You need durable medical equipment (DME)** | | | Wheelchairs | | $0 | | |  | | |
| Canes | | $0 | | |  | | |
| Crutches | | $0 | | |  | | |
| Walkers | | $0 | | |  | | |
| Oxygen | | $0 | | |  | | |
| **You need help living at home** | | | Meals brought to your home | | $0 | | | [*For all LTSS, indicate if services are only available to beneficiaries on a waiver.*] Services are only available to individuals on the MI Health Link 1915(c) waiver. | | |
| Home services, such as cleaning or housekeeping | | $0 | | |  | | |
| Changes to your home, such as ramps and wheelchair access | | $0 | | | Services are only available to individuals on the MI Health Link 1915(c) waiver. | | |
| Personal care services  (You may be able to employ your own personal care assistant. Call Member Services for more information.) | | $0 | | |  | | |
| Home health care services | | $0 | | |  | | |
| Adult day services or other support services | | $0 | | | Services are only available to individuals on the MI Health Link 1915(c) waiver. | | |
| **You need a place to live with people available to help you** | | Nursing home care | | | A patient pay amount may be required for non-skilled days of service. | | | Services are only available to individuals who meet the Michigan Medicaid Nursing Facility Level of Care Determination standards. | | |
| **Your caregiver needs some time off** | | | Respite care | | $0 | | | |  | |

**Other services that <plan name> covers**

This is not a complete list. Call Member Services or read the Member Handbook to find out about other covered services.

| **Other services covered by <plan name>** | **Your costs for in-network providers** |
| --- | --- |
| [*Insert special services offered by your program. This does not need to be a comprehensive list.*] | [*Plans should include co-pays for listed services.*] |
|  |  |
|  |  |
|  |  |

**Services that <plan name> does not cover**

This is not a complete list. Call Member Services to find out about other excluded services.

| **Services not covered by <plan name>** | |
| --- | --- |
| [*Insert any excluded benefit categories. This does not need to be a comprehensive list. However, this should include benefit categories that are carved out of the plan.*] |  |
| Hospice Services |  |
|  |  |
|  |  |

**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 will tell you about your rights at least once a year. For more information on your rights, please read the Member Handbook. Your rights include, but are not limited to, the following:

* **You have a right to respect, fairness and dignity.** This includes the right:
  + To get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
  + To request information in other formats (e.g., audio CD‑ROM, large print, cassette, Braille)
  + To be free from any form of restraint or seclusion
  + To not be billed by network providers
* **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 format you can understand. These rights include getting 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 managers
* **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 you can change your PCP at any time
  + To see a women’s health care provider without a referral
  + To get your covered services and drugs quickly
  + To know about all treatment options, no matter what they cost or whether they are covered
  + To refuse treatment, even if your doctor advises against it
  + To stop taking medicine
  + To ask for a second opinion. <plan name> will pay for the cost of your second opinion visit.
* **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right:
  + To get medical care timely
  + To 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
  + To have interpreters to help with communication with your doctors 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 approval in an emergency
  + To see 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.
  + To have your personal health information kept private.
* **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
  + To ask for a state fair hearing
  + To get a detailed reason for why services were denied

For more information about your rights, you can read the <plan name> Member Handbook. If you have questions, you can also call <plan name> Member Services.

**If you have a complaint or think we should cover something we denied**

If you have a complaint or think <plan name> should cover something we denied, call <plan name> at <toll-free number>. You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the <plan name> Member Handbook. You can also call <plan name> Member Services.

[*Plans should include contact information for complaints, grievances, and appeals.*]

**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 on the cover of this summary.
* Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
* Or, contact the Michigan Attorney General’s Health Care Fraud Division Hotline by phone at (800) 24-ABUSE [800-242-2873], via e-mail at [hcf@michigan.gov](mailto:hcf@michigan.gov) or use the on-line Medicaid Fraud Complaint Form found at <http://www.michigan.gov/ag/0,1607,7-164-17331-46928--,00.html>.