**Instructions to Health Plans**

* [Plans should follow the instructions in the State-specific Marketing Guidance regarding use of the standardized plan type (Medicare-Medicaid Plan) following the plan name. Plans should not use ICO when referring to themselves. Plans should use health plan or MI Health Link where appropriate.]
* [Plans may add a cover page to the Summary of Benefits. Plans may include the Material ID only on the cover page.]
* [Plans should replace the reference to “Member Services” with the term the plan uses.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [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 members in a waiver program, in which case plans should indicate that State eligibility requirements may apply.]
* [Plans may place a QR code on materials to provide an option for members to go online.]
* [Wherever possible, plans are encouraged to adopt good 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 an 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, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).
* Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.
* 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.
* Consider producing translated models in large print.]

**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 *Member Handbook*.

[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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# Disclaimers

Description: Exclamation in boxThis 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. [*Plans must include information about how to contact Member Services to get a Member Handbook and how to access the Member Handbook on the plan’s website.*]

* [Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.]
* Under <plan name> you can get your Medicare and Michigan 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*.
* ATTENTION: If you speak [insert language of the disclaimer], language assistance services, free of charge, are available to you. Call [insert Member Services toll-free phone and TTY numbers, and days and hours of operation]. The call is free. [This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation. If the plan doesn’t meet either the Medicare or state thresholds for translation of written materials, the disclaimer should not be included.]
* [*Plans may increase the font size and/or use bold font to emphasize the following information.*]You can also get this document for free in other formats, such as large print, braille, or audio. Call [insert Member Services toll-free phone and TTY numbers, days and hours of operation]. The call is free.
* [*Plans also must describe in simple terms:*
* how they will request a member’s preferred language other than English and/or alternate format,
* how they will keep the member’s information as a standing request for future mailings and communications so the member does not 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

The following chart lists frequently asked questions.

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

| **Frequently Asked Questions (FAQ)** | **Answers** |
| --- | --- |
| **What is a Medicare-Medicaid Plan?** | A Medicare-Medicaid Plan 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 Michigan Medicaid. 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 Care Coordinator?** | A Care Coordinator is a health professional who will help you get care and services that affect your health and wellbeing. You are assigned a Care Coordinator when you enroll with <plan name>. Your Care Coordinator will get to know you and will work with you, your doctors, and other care givers to make sure everything is working together for you. You can share your health history with your Care Coordinator and set goals for healthy living. Whenever you have a question or a problem about your health or services or care you are getting from us, you can call your Care Coordinator. **Your Care Coordinator is your “go-to” person** for <plan name>.  Our goal in <plan name> is to meet your needs in a way that works for you. This is why we call our program “person-centered.” The person-centered planning process is when you work with your Care Coordinator to create a care plan that is about **your** goals, choices, and abilities. When you create your care plan, you are welcome to involve people you feel are key to your success, such as family members, friends, or legal representatives. |
| **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 I get the same Medicare and Michigan Medicaid benefits in <plan name> that I get now?** | You will get your covered Medicare and Michigan 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 getting services for mental health, substance use, or intellectual/developmental disability needs, you will continue to get 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 using your doctors and getting your current services for up to 90 days, or 180 days depending on the service, while your IICSP 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 I use the same doctors I use 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 using 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* on the plan’s website at <web address>.  If <plan name> is new for you, you can continue using the doctors you use now while your IICSP is being developed. |
| **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 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. Call Member Services for more information about whether the plan is available where you live.] |
| **Do I 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. (You will be required to keep paying any monthly Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting [www.michigan.gov/mdhhs/0,5885,7-339-73970\_5461---,00](https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html).) |
| **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 use 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.  Refer to Chapter 3 [plans may insert reference, as applicable] of the *Member Handbook* to learn more about prior authorization. Refer to the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a prior authorization. |
| **What is a referral?**  [If a plan does not require referrals for any of its services, the plan may delete this question.] | A referral means that your primary care provider (PCP) must give you approval before you can go to someone that is not your PCP or use other providers in the plan’s network. If you don’t get approval, <plan name> may not cover the services. You don’t need a referral for certain specialists, such as women’s health specialists.  Refer to Chapter 3 [plans may insert reference, as applicable] of the *Member Handbook* to learn more about when you will need to get a referral from your PCP. |
| **Whom should I contact if I have questions or need help? (continued on the next page)**  [Plans may 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 your Care Coordinator or <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 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 free. <Days and hours of operation.> | |
| **Whom should I contact if I have questions or need help? (continued from previous page)**  [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 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.> |   **If you have questions about behavioral health services and resources, please call the PIHP General Information Line. If you need immediate behavioral health services, please call the Behavioral Health Crisis Line for the local Prepaid Inpatient Health Plan (PIHP).**  [Plans with multiple PIHP contracts may duplicate the table rows below to reflect information about multiple contracts. Insert PIHP information for relevant county:]   | **CALL** | **PIHP General Information Line**  <Phone number>  Calls to this number are [Insert if applicable: not] free. <Days and hours of operation.> | | --- | --- | | **TTY** | <TTY phone number> | |
| **Whom should I contact if I have questions or need help? (continued from previous page)**  [Plans may modify the call-lines as appropriate] | [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.>   | **CALL** | **Behavioral Health Crisis Line** <Phone number>  Calls to this number are [Insert if applicable: not] free. <Days and hours of operation.> | | --- | --- | | **TTY** | <TTY 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.> | |

# Overview of Services

The following chart is a quick overview of what services you may need, your costs, and rules about the benefits. [Plans should add text in bold at the end of a service title if the service continues onto the next page: **(This service is continued on the next page)**. Plans should add text in bold after the service title on the following page: **<name of service>** **(continued)**. Plans should also be aware that the flow of services from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed. Additionally, plans should maintain consistency of table formatting, borders, and color scheme throughout after adding plan-customized information.]

| **Health need or problem** | **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 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 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 (This service is continued on the next page)** | 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 refer to <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 refer to <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.] |
| **You need drugs to treat your illness or condition (continued)** | Over-the-counter drugs | $0 | 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. |
| Medicare Part B prescription 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 *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 aid evaluation and fitting | $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 Prepaid Inpatient Health Plan (PIHP) |
| **You have concerns related to substance use** | Substance use services | $0 | Provided through the Prepaid Inpatient Health Plan (PIHP) |
| **You need durable medical equipment (DME)** | Wheelchairs | $0 |  |
| Nebulizers | $0 |  |
| Crutches | $0 |  |
| Walkers | $0 |  |
| Oxygen equipment and supplies | $0 |  |
| **You need help living at home (This service is continued on the next page)** | Meals brought to your home | $0 | [For all LTSS listed in this section, plans may remove the following language if they offer a specific service to all eligible members, not just those enrolled in the MI Health Link 1915(c) waiver.] Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| Chore services, such as heavy household chores and mowing and raking | $0 | Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| Preventive nursing services | $0 | Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| Private duty nursing services to provide skilled nursing services in your home | $0 | Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| Fiscal intermediary services to help you control your budget and choose the staff to work with you | $0 | Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| **You need help living at home (continued)** | Environmental modifications to your home, such as adding ramps and widening doorways | $0 | Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| Expanded community living supports to help you complete activities of daily living and instrumental activities of daily living | $0 | Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| Personal care services  (You may be able to choose your own personal care assistant. Call Member Services for more information.) | $0 | [Plans may not include language that limits this service to only individuals in the MI Health Link 1915(c) waiver as this service is offered to all individuals in MI Health Link as long as they are eligible for the service.] |
| Personal Emergency Response System (PERS) | $0 | [Plans may not include language that limits this service to only individuals in the MI Health Link 1915(c) waiver as this service is offered to all individuals in MI Health Link as long as they are eligible for the service.] |
| Assistive technology | $0 | Services are only available to individuals on the MI Health Link 1915(c) waiver. |
| **You need help living at home (continued)** | 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 (PPA) may be required. | 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 |  |
| **Additional covered services** [*Plans are encouraged to insert other services they offer that are not already included in the chart. This does not need to be a comprehensive list.*] |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Services covered outside of <plan name>

This is not a complete list. Call your Care Coordinator or Member Services to find out about other services not covered by <plan name> but available through Medicare or Michigan Medicaid.

| **Other services covered by Medicare or Michigan Medicaid**  [Insert services covered outside the plan by Medicare fee-for-service and/or Michigan Medicaid fee-for-service, as appropriate. This does not need to be a comprehensive list. Plans may consult Section F of Chapter 4 of the Member Handbook for examples.] | **Your costs**  [Plans should include copays for listed services.] |
| --- | --- |
| Prepaid Inpatient Health Plan (PIHP) services: Inpatient behavioral health care, outpatient substance use disorder services, and partial hospitalization services |  |
| Some hospice care services | $0 |
|  |  |

# Services that <plan name>, Medicare, and Michigan Medicaid do not cover

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

| **Services not covered by <plan name>, Medicare, or Michigan Medicaid** | |
| --- | --- |
| [Insert any excluded benefit categories. This does not need to be a comprehensive list. Plans may consult Section G of Chapter 4 of the Member Handbook for examples.] |  |
|  |  |
|  |  |
|  |  |

# 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
  + Get information in other formats (e.g., large print, braille, audio)
  + Be free from any form of physical restraint or seclusion
  + 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 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 are covered
  + Refuse treatment, even if your doctor advises against it
  + Stop taking medicine
  + 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 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 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
  + 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.
* **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
  + Ask for a state fair hearing
  + 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.

# 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 <plan name> at the number at the bottom of the page. You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 [plans may insert reference, as applicable] of the <plan name> *Member Handbook*. You can also call <plan name> Member Services.

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

# What do you 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 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], by e-mail at [hcf@michigan.gov](mailto:hcf@michigan.gov) or use the on-line Michigan Medicaid Fraud Complaint Form found at [secure.ag.state.mi.us/complaints/medicaid.aspx](https://secure.ag.state.mi.us/complaints/medicaid.aspx).