Instructions to the Health Plan

* [The plan may add a cover page to the Summary of Benefits. The plan may include the Material ID only on the cover page.]
* [Where the template instructs inclusion of a phone number, the plan must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [The plan should note that any reference to a “Participant Handbook” is also a reference to the Evidence of Coverage document.]
* [The plan 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, the plan should provide specific information about need for prior authorization (PA), utilization management restrictions for drugs, permissible OON services, and applicable cost sharing (if different than in-plan cost sharing).]
* [The plan may place a QR code on materials to provide an option for Participants to go online.]
* [Wherever possible, the plan is 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 Covered Items and Services Chart in Chapter 4 of the Participant 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 Participant of <plan name>. Key terms and their definitions appear in alphabetical order in the last chapter of the Participant Handbook.

[The plan 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

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

* [The plan must include all applicable disclaimers as required in the State-specific Marketing Guidance.]
* Under <plan name> you can get your Medicare and Medicaid services in one managed care plan called a Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Plan. A <plan name> Care Manager will help manage your 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 *Participant Handbook*.
* ATTENTION: If you speak [insert language of the disclaimer], language assistance services, free of charge, are available to you. Call [insert Participant 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.]
* You can get this document for free in other formats, such as large print, braille, or audio. Call [insert Participant Services toll-free phone and TTY numbers, and days and hours of operation]. The call is free.
* [*The plan also must simply describe:*
  + *how it will request a Participant’s preferred language other than English and/or alternate format,*
  + *how it will keep the Participant’s information as a standing request for future mailings and communications so the Participant does not need to make a separate request each time,* ***and***
  + *how a Participant can change a standing request for a preferred language and/or format*.]
* The State of New York has created a Participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800) or online at [icannys.org](http://icannys.org/).

# Frequently Asked Questions

The following chart lists frequently asked questions. [The plan 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)**. The plan should add text in bold after the FAQ title on the following page: **<FAQ> (continued from previous page)**. The plan should also be aware that the flow of FAQ 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 FAQ as needed. Additionally, the plan should maintain consistency of table formatting, borders, and color scheme throughout after adding plan-customized information.]

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

| **Frequently Asked Questions (FAQ)** | **Answers** |
| --- | --- |
| **What is a Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities** **(FIDA-IDD) Plan?** | A FIDA-IDD Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services, developmental disability service providers, and other providers. It also has Care Managers and Interdisciplinary Teams (IDTs) to help you plan and manage all your providers and services. They all work together to provide the care you need. <Plan name> is a FIDA-IDD Plan that provides benefits of Medicaid and Medicare to Participants in the FIDA-IDD Demonstration. |
| **What is a <plan name> Care Manager and Interdisciplinary Team (IDT)?** | A <plan name> Care Manager is one main person that you may contact. This person helps manage all your providers and services and makes sure you get what you need. This person is part of your IDT, which also includes:   * + - You and your caregiver/guardian or designee(s);     - Your primary providers of developmental disability services, who have knowledge of your desired outcomes and service needs;     - Additional individuals, including:       * Your Primary Care Provider (PCP) or a designee from your PCP’s office (or practice) who has clinical experience and knowledge of your needs;       * Your Behavioral Health (BH) Professional, if you have one, or a designee from your BH Professional’s office (or practice) who has clinical experience and knowledge of your needs;       * Your home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of your needs, if you are getting home care and approve the home care aide/designee’s participation on the IDT;       * A clinical representative from your Intermediate Care Facility (ICF), if getting ICF care; **and**       * Other providers either as you or your caregiver/guardian or designee ask for or as recommended by the IDT members as necessary for adequate care planning and approved by you or designee. |
| **What are long-term services and supports (LTSS)?** | LTSS 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 facility or hospital. |
| **Is Self-Direction an option for me?** | If you are enrolled in the Office for People With Developmental Disabilities (OPWDD) Home and Community Based Services (HCBS) comprehensive waiver you have the option to self-direct certain developmental disability services and supports. |
| **Can I direct my own care or hire my own aides?** | You have the right to choose to direct your own care by selecting Consumer Directed Personal Assistance Services (CDPAS). Through CDPAS, you can hire your own aides and make other decisions about how to get services. |
| **Will I get the same Medicare and Medicaid benefits in <plan name> that I 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. You will get almost all of your covered Medicare and Medicaid benefits directly from <plan name>, but you will get Hospice Services the same way you do now, outside of the plan.  When you enroll in <plan name>, you and your Interdisciplinary Team (IDT) will work together to develop a Life Plan to address your health and support needs. When you first enroll in <plan name>, you can keep using your doctors and getting your current services for 90 days, or until your Life Plan is complete, whichever is later. However, you can choose to begin getting services in accordance with your approved Life Plan prior to 90 days. 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, developmental disability service providers 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, unless <plan name> or your IDT has authorized you to use an out-of-network provider. * If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of <plan name>'s plan. [The plan may insert additional exceptions as appropriate.]   To find out if your doctors and service providers are in the plan’s network, call Participant 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 and service providers you use now for 90 days or until your Life Plan is complete, whichever is later. However, you can choose to begin getting services in accordance with your approved Life Plan prior to 90 days.  If you currently get behavioral health services, your Interdisciplinary Team (IDT) will review your current episode of care to decide if you can continue the services with the same provider you use now. If they or <plan name> decide you can use the same provider you use now, you will be able to use that provider for 24 months following your enrollment in <plan name>. |
| **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: [The plan should entercounty **or** counties] Counties, <State>. You must live in [the plan should enter this area **or** one of these areas] to join the plan. |
| **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 coverage. You also will not have any copays or other costs when you get care from network providers. |
| **What is prior authorization (PA)?** | PA means that you must get approval from <plan name> or your Interdisciplinary Team (IDT) before you can get a specific service, item, or drug or before you can use an out-of-network provider. <Plan name> may not cover the service, item, or drug if you don’t get approval from <plan name> or your IDT. Refer to Chapter 3, [plan may insert reference, as applicable] of the *Participant Handbook* to learn more about PA.  A small number of services require PA by a specialist and not by <plan name> or your IDT. Please refer to Chapter 4 of your *Participant Handbook* for more information. <Plan name> can also provide you with a list of services or procedures that require you to get PA from a provider other than your IDT.  Some services do not require any PA, such as emergency or urgently needed care, out-of-area dialysis services, Primary Care Provider (PCP) visits, and women’s health specialist services. For the full list of services that do not require PA, please refer to Chapter 4 of your *Participant Handbook* or call <plan name>. |
| **What is a referral?** | A referral means that your Primary Care Provider (PCP) gives you approval to use a provider other than your PCP. Referrals are not necessary in <plan name> and will not be required. However, PA rules must be followed. |
| **Who should I contact if I have questions or need help? (continued on the next page)** [The plan may modify the call-lines as appropriate] | **If you have general questions or questions about our plan, services, service area, billing, or Participant ID Cards, please call <plan name> Participant Services:**   | **CALL** | <Phone number(s)>  Calls to this number are free. <Days and hours of operation.> [Include information on the use of alternative technologies.]  Participant 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.> |   **If you have questions about your health, please call the Nurse Advice Call 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.> | |
| **Who should I contact if I have questions or need help? (continued from previous page)** [The plan may modify the call-lines as appropriate] | [Insert if applicable: **If you need immediate behavioral health services, please call the Behavioral Health 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 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. [The plan 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)**. The plan should add text in bold after the service title on the following page: **<name of service> (continued)**. The plan 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, the plan 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 Participants 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** | **Limitations, exceptions, & benefit information (rules about benefits)** [The Plan should provide specific information about: need for PA, utilization management restrictions for drugs, and permissible OON services and applicable cost sharing (if different than in-network cost sharing).] |
| --- | --- | --- | --- |
| **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 for a [must be at least 30-day]supply.  [The plan should insert the following for each extended day supply they offer: $0 for a <extended day>-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.  [The plan must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations.] |
| **You need drugs to treat your illness or condition (continued)** | Brand name drugs | $0 for a [must be at least 30-day] supply.  [The plan should insert the following for each extended day supply they offer: $0 for a <extended day>-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.  [The plan must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations.] |
| Over-the-counter (OTC) drugs | $0 | <Plan name> covers some OTC drugs when they are written as prescriptions by your provider. 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 *Participant 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 | [The plan must state that emergency room services must be provided OON and without PA requirements.] |
| Ambulance services | $0 |  |
| Urgent care | $0 | [The plan must state that urgent care services must be provided OON and without PA 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 or contact lenses | $0 |  |
| **You need dental care** | Dental check-ups | $0 |  |
| **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** | Mental or behavioral health services | $0 |  |
| **You have a substance abuse problem** | Substance abuse services | $0 |  |
| **You need long-term mental health services** | Inpatient care for people who need mental health care | $0 |  |
| **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** | Home services, such as cleaning or housekeeping | $0 |  |
| Personal care assistant  (You may be able to employ your own assistant. Call Participant Services for more information.) | $0 |  |
| Home health care services | $0 |  |
| Services to help you live on your own | $0 |  |
| Adult day services or other support services | $0 |  |
| **You need a place to live with people available to help you** | Intermediate Care Facility (ICF) | $0 |  |
| Nursing facility care | $0 |  |
| **Additional covered services** [*The plan is encouraged to insert other services it offers, including waiver services 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 Participant Services to find out about other services not covered by <plan name> but available through Medicare or Medicaid.

| **Other services covered by Medicare or Medicaid** | **Your costs** |
| --- | --- |
| [Insert services covered outside the plan by Medicare fee-for-service and/or Medicaid fee-for-service, as appropriate. This does not need to be a comprehensive list.] | [The plan should include copays for listed services.] |
| Freestanding birth center services | $0 |
| Hospice services | $0 |
|  |  |

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

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

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

# Your rights as a Participant of the plan

As a Participant of <plan name>, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your services from <plan name>. We will tell you about your rights at least once a year. For more information on your rights, please read the *Participant Handbook.* This is not a complete list of all your rights. 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
  + Have your questions and concerns answered completely and courteously
  + Freely apply your rights without any negative effect on the way <plan name> or your provider treats you
* **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 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
* Participate in Interdisciplinary Team (IDT) meetings about your care
* 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
* Create and apply an advance directive, such as a living will or health care proxy
* **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 PA 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
  + Direct your own care or hire your own aides through Consumer-Directed Personal Assistance Services (CDPAS)
* **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
  + Get a detailed reason for why services were denied

For more information about your rights, you can read the <plan name> *Participant Handbook*. If you have questions, you can also call <plan name> Participant 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 <toll-free number>. You may be able to appeal our decision.

For questions about grievances (complaints) and appeals, you can read Chapter 9 of the <plan name> *Participant Handbook* [*plan may insert reference, as applicable*]. You can also call <plan name> Participant Services at the number at the bottom of this page.

Additionally, you can get help from the Independent Consumer Advocacy Network (ICAN). ICAN can give you free, confidential assistance on any services offered by <plan name>, including any problems getting quality care. ICAN may be reached at 1-844-614-8800 (TTY users, call 711) or online at [icannys.org](http://icannys.org/).

[The plan should include contact information for complaints, grievances, and appeals.]

# 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> Participant 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.
* [The plan may also insert additional State-based resources for reporting fraud.]