Instructions to Health Plan

* [Plan may add a cover page to the Summary of Benefits. Plan may include the Material ID only on the cover page.]
* [Where the template instructs inclusion of a phone number, plan must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [Plan should note that any reference to a “Member Handbook” is also a reference to the Evidence of Coverage document.]
* [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, plan should provide specific information about need for referrals, need for prior authorization (PA), utilization management restrictions for drugs, maximum out of pocket costs on services, permissible OON services, and applicable cost sharing (if different than in-plan cost sharing).]
* [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 the plan should indicate that State eligibility requirements may apply.]
* [Plan may place a QR code on materials to provide an option for members 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 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*.

[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 *Member Handbook* for the full list of benefits. [*Plan 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.*]

* [Plan must include all applicable disclaimers as required in the State-specific Marketing Guidance.]
* [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.]
* Under <plan name> you can get your Medicare and Rhode Island Medicaid services in one health plan. A <plan name> care manager 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]. TTY users should call <TTY number>. The call is free.[This disclaimer must be included in Spanish and 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 Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <TTY number>. The call is free.
* [*Plan also must simply describe:*
  + *how it will request a member’s preferred language other than English and/or alternate format,*
  + *how it 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.

[Plan may add a maximum of two additional FAQs to this section. For example, 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 Medicare-Medicaid Plan?** | A Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Rhode Island Medicaidto provide benefits of both programs to enrollees. It is for people with both Medicare and 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 managers 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 manager?** | A <plan name> care manager 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 services and supports?** | Long-term services and supports (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 home or hospital. Our plan covers LTSS for members who need them and qualify for LTSS through Rhode Island Medicaid. You may need to pay for part of the cost of the services. This is called “cost-share,” and the amount you pay is determined by Rhode Island Medicaid. |
| **Will I get the same Medicare and Rhode Island Medicaid benefits in <plan name>** **that I get now?** | You will get your covered Medicare and Rhode Island 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. [Plan should add if applicable:You will get almost all of your covered Medicare and Rhode Island Medicaid benefits directly from <plan name>, but you may get some benefits the same way you do now, outside of the plan.]  When you enroll in <plan name>, you and your care team will work together to develop an Individualized Care Plan to address your health and support needs. During this time, [Plan should add information about continuity of care:e.g., you can keep using your doctors and getting your current services for 90 days, or until your care plan is complete]. When you join our plan, if you are taking any Medicare Part D prescription drugs or Rhode Island Medicaid covered 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. [Plan 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 for [plan should discuss the state’s continuity of care requirement, e.g., for 90 days.] |
| **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 is The State of Rhode Island. You must live in Rhode Island to join the plan.  [Plan 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.  [If the plan has a monthly premium that was approved by CMS and the state, the plan should discuss it here.] |
| **What is prior authorization (PA)?** | PA 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, [plan may insert reference, as applicable] of the *Member Handbook* to learn more about PA. Refer to the Benefits Chart in Section D of Chapter 4 of the *Member Handbook* to learn which services require a PA. |
| **What is a referral?**  [If the 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 use 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 to use certain specialists, such as women’s health specialists.  Refer to Chapter 3, [plan may insert reference, as applicable]of the *Member Handbook* to learn more about when you will need to get a referral from your PCP. |
| **Do I pay a deductible?** | No. You do not pay deductibles in <plan name>. |
| **What is Extra Help?**  [If the plan is electing to reduce Part D copays to $0, the plan may delete this question.] | Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”  Your prescription drug copays under <plan name> already include the amount of Extra Help you qualify for. For more information about Extra Help, contact your local Social Security Office, or call Social Security at 1-800-772-1213. TTY users may call 1-800-325-0778. [Plan may substitute TTY number with or add contact information for Video Relay or other accessible technology.] |
| **Do I have a coverage gap for drugs?** | No. Because you have Medicaid you will not have a coverage gap stage for your drugs. |
| **Who should I contact if I have questions or need help? (continued on the next page)** [Plan 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 <plan name> Member Services:**   |  |  | | --- | --- | | **CALL** | <toll-free number>  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 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>. | |
| **Who should I contact if I have questions or need help? (continued from previous page)** [Plan may modify the call-lines as appropriate.] | **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>. |   [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. [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)**. Plan should add text in bold after the service title on the following page: **<name of service> (continued)**. 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 members may need. The health plan should add or delete any services based on the services covered by the State and/or health plan.] | **Your costs for in-network providers** [Plan should insert cost sharing where applicable.] | **Limitations, exceptions, & benefit information (rules about benefits)** [Plan should provide specific information about: need for referrals, need for PA, 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 want a doctor** | Visits to treat an injury or illness | [$–] |  |
| Wellness visits, such as a physical | [$–] |  |
| Transportation to a doctor’s office | [$–] |  |
| Specialist care | [$–] |  |
| Care to keep you from getting sick, such as flu shots | [$–] |  |
| **You need medical tests (This service is continued on the next page)** | Lab tests, such as blood work | [$–] |  |
| **You need medical tests (continued)** | X-rays or other pictures, such as CAT scans | [$–] |  |
| Screening tests, such as tests to check for cancer | [$–] |  |
| **You need drugs to treat your illness or condition (This service is continued on the next page)** | Generic drugs (no brand name) | [Plan should insert a single amountorall applicable copay amounts for a tier with LIS copay amounts] for a [must be at least 30-day] supply.  [Plan may delete the following statement if they charge $0 for all generic drugs.]  Copays for prescription 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.  [Plan may delete the following statement if they only have one coverage stage.] Once you or others on your behalf pay <insert TrOOP amount> you have reached the catastrophic coverage stage and you pay $0 for all your Medicare drugs. Read the *Member Handbook* for more information on this stage.  **Important Message About What You Pay for Vaccines –** Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary).* Our plan covers most Part D vaccines at no cost to you.  [Plan 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)** | Brand name drugs | [Plan 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.  [Plan may delete the following statement if they charge $0 for all brand name drugs.] Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details. | There may be limitations on the types of drugs covered. Please refer to <plan name>’s *List of Covered Drugs* (Drug List) for more information.  [Plan must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations and make clear that the cost sharing amount for these extended-day supplies is the same as for a one-month supply.] |
| Over-the-counter drugs | [Plan should insert a single amount, multiple amounts, or minimum/ maximum range.] | There may be limitations on the types of drugs covered. Please refer to <plan name>’s *List of Covered Drugs* (Drug List) for more information. |
| **You need drugs to treat your illness or condition (continued)** | Medicare Part B prescription drugs | [$–] | 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 | [$–] |  |
| **You need emergency care** | Emergency room services | [$–] | [Plan must state that emergency room services must be provided OON and without PA requirements.] |
| Ambulance services | [$–] |  |
| Urgent care | [$–] | [Plan must state that urgent care services must be provided OON and without PA requirements.] |
| **You need hospital care** | Hospital stay | [$–] |  |
| Doctor or surgeon care | [$–] |  |
| **You need help getting better or have special health needs** | Rehabilitation services | [$–] |  |
| Medical equipment for home care | [$–] |  |
| Skilled nursing care | [$–] |  |
| **You need eye care** | Eye exams | [$–] |  |
| Glasses or contact lenses | [$–] |  |
| **You need dental care** | Dental check-ups | [$–] |  |
| **You need hearing/ auditory services** | Hearing screenings | [$–] |  |
| Hearing aids | [$–] |  |
| **You have a chronic condition, such as diabetes or heart disease have a chronic condition, such as diabetes or heart disease** | Services to help manage your disease | [$–] |  |
| Diabetes supplies and services | [$–] |  |
| **You have a mental health condition** | Mental or behavioral health services | [$–] |  |
| **You have a substance use problem** | Substance use treatment services | [$–] |  |
| **You need long-term mental health services** | Inpatient care for people who need mental health care | [$–] |  |
| **You need durable medical equipment (DME)** | Wheelchairs | [$–] |  |
| Nebulizers | [$–] |  |
| Crutches | [$–] |  |
| Walkers | [$–] |  |
| Oxygen equipment and supplies | [$–] |  |
| **You need help living at home (This service is continued on the next page)** | Meals brought to your home | [$–] | [For all LTSS, indicate if services are only available to members on a waiver.] |
| Home services, such as cleaning or housekeeping | [$–] |  |
| **You need help living at home (continued)** | Changes to your home, such as ramps and wheelchair access | [$–] |  |
| Personal care assistant  (You may be able to employ your own assistant. Call Member Services for more information.) | [$–] |  |
| Training to help you get paid or unpaid jobs | [$–] |  |
| Home health care services | [$–] |  |
| Services to help you live on your own | [$–] |  |
| Adult day services or other support services | [$–] |  |
| **You need a place to live with people available to help you** | Assisted living or other housing services | [$–] |  |
| Nursing home care | [$–] |  |
| **Your caregiver needs some time off** | Respite care | [$–] |  |
| **Additional covered services** [*Plan is encouraged to insert other services offered 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 Member Services to find out about other services not covered by <plan name> but available through Medicare [insert if appropriate: or Rhode Island Medicaid].

| **Other services covered by Medicare [insert if appropriate: or Rhode Island 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.] | [Plan should include copays for listed services.] |
| Some hospice care services | $0 |
|  |  |
|  |  |

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

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

| **Services not covered by <plan name>, Medicare, or Rhode Island Medicaid** | |
| --- | --- |
| [Insert any excluded benefit categories. This does not need to be a comprehensive list. Plan 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, gender identity, 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 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 <toll-free number>. You may be able to appeal our decision.

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

[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> 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.
* [Plan may also insert additional State-based resources for reporting fraud.]