**Instructions to Health Plans**

* [Plans may add a cover page to the Summary of Benefits. Plans may include the Marketing Material ID only on the cover page.]
* [*Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY/TDD number and days and hours of operation.*]
* [*Plans should note that any reference to a “Participant 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 prior authorization, utilization management restrictions for drugs, permissible OON services, and applicable cost sharing (if different than in-plan cost sharing).*]
* [*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*https://www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]
* [*Plans may place a QR code on materials to provide an option for Participants 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 to 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 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 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.

[*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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A. 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.

* [*Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.*]
* Under <plan name> you can get your Medicare and Medicaid services in one managed care plan called a FIDA 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/TDD 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/TDD numbers and days and hours of operation*]. The call is free.
* [*Plans must simply describe how they will request a Participant’s preferred language and/or format and keep the information as a standing request for future mailings and communications. Plans must also describe how a Participant can change a standing request for 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 or online at [icannys.org](http://icannys.org/). (TTY users call 711, then follow the prompts to dial 844-614-8800.)

**B.** Frequently Asked Questions

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

[*Plans 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 Fully Integrated Duals Advantage (FIDA) Plan?** | A Fully Integrated Duals Advantage (FIDA) Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Managers and Interdisciplinary Teams 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 Plan that provides benefits of Medicaid and Medicare to Participants in the FIDA Demonstration. |
| **What is a <plan name> Care Manager and Interdisciplinary Team (IDT)? (continued on the next page)** | 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 Interdisciplinary Team (IDT), which also includes you and your designee(s). You may also choose to have any of the following people participate in any or all of your IDT meetings:   * + - 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;     - A clinical representative from your nursing facility, if getting nursing facility care; and     - Additional individuals including: * Other providers either as asked for by you or your designee, or as recommended by the IDT members as necessary for adequate care planning and approved by you or your designee; or * The registered nurse (RN) who completed your assessment. |
| **What is a <plan name> Care Manager and Interdisciplinary Team (IDT)? (continued from previous page)** |
| **What are long-term services and supports?** | Long-term services and supports 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. |
| **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 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. You will get almost all of your covered Medicare and Medicaid benefits directly from <plan name>, but you will get four benefits the same way you do now, outside of the plan. These benefits include: Hospice Services, Out-of-Network Family Planning Services, Methadone Maintenance Treatment Program, and Directly Observed Therapy for Tuberculosis Disease.  When you enroll in <plan name>, you and your Interdisciplinary Team (IDT) will work together to develop a Person-Centered Service Plan (PCSP) to address your health and support needs. When you first enroll in <plan name>, you can keep seeing your doctors and getting your current services for 90 days, or until your PCSP is complete, whichever is later. 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, unless <plan name> or your IDT has authorized you to see 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. [*Plans may insert additional exceptions as appropriate.*]   To find out if your doctors are in the plan’s network, call Participant 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 for 90 days or until your Person-Centered Service Plan is complete, whichever is later. 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 see now. If they decide you can see the same provider you see now, you will be able to see that provider for 24 months following your enrollment in <plan name>. |
| **Can you remain in the same nursing facility you live in now?** | Yes. If you live in a nursing facility when you enroll in <plan name>, you can remain in that nursing facility for the entire time that you are in a FIDA Plan like <plan name>, even if that nursing facility is out-of-network and does not participate with <plan name>. |
| **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, <State>. You must live in [*plans should enter* this area ***or*** one of these areas] to join the plan. |
| **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 coverage. You also will not have any copays or other costs when you get care from network providers. |
| **What is prior authorization?** | Prior authorization 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 see 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. A small number of services require prior authorization 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 prior authorization from a provider other than your IDT.   Some services do not require any prior authorization, such as emergency or urgently needed care, out-of-area dialysis services, primary care provider visits, and women’s health specialist services. For the full list of services that do not require prior authorization, please see Chapter 4 of your *Participant Handbook* or call <plan name> to learn which services require prior authorization. |
| **What is a referral?** | A referral means that your Primary Care Provider gives you approval to see someone that is not your Primary Care Provider. Referrals are not necessary in <plan name> and will not be required. However, prior authorization rules must be followed. |
| **Who should you contact if you 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 Participant ID Cards, please call <plan name> Participant Services:**   | **CALL** | <Toll-free 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** | <Toll-free 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 free. <Days and hours of operation.> | |
| **Who should you contact if you 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 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/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:**   | **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.>] | |

C. 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 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** | **Limitations, exceptions, & benefit information (rules about benefits)** [*Plans should provide specific information about: need for prior authorization, utilization management restrictions for drugs, and permissible OON services and applicable cost sharing (if different than in-network cost sharing).*] |
| --- | --- | --- | --- |
| **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 (This service is continued on the next page)** | Generic drugs (no brand name) | $0 for a [*must be at least 30-day*] supply.  [*Plans 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 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.*] |
| **You need drugs to treat your illness or condition (continued)** | Brand name drugs | $0 for a [*must be at least 30-*day] supply.  [*Plans 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 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.*] |
| Over-the-counter drugs | $0 | <Plan name> covers some OTC drugs when they are written as prescriptions by your provider. 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 *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 | [*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 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 (This service is continued on the next page)** | | | Meals brought to your home | $0 | [*For all LTSS, indicate if services are only available to beneficiaries on a waiver.*] | |
| Home services, such as cleaning or housekeeping | $0 |  | |
| Changes to your home, such as ramps and wheelchair access | $0 |  | |
| **You need help living at home (continued)** | | | Personal care assistant  (You may be able to employ your own assistant. Call Participant Services for more information.) | $0 |  | |
| Training to help you get paid or unpaid jobs | $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** | | | Assisted living or other housing services | $0 |  | |
| Nursing facility care | $0 |  | |
| **Your caregiver needs some time off** | | | Respite care | $0 |  | |

D. Other services that <plan name> covers

This is not a complete list. Call Participant Services or read the *Participant 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.*] | $0 |
|  |  |
|  |  |

E. Benefits 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.*] | [*Plans should include copays for listed services.*] |
| Day treatment | $0 |
| Freestanding birth center services |  |
| Out of network family planning services |  |
| Methadone Maintenance Treatment Program (MMTP) |  |
| Directly observed therapy for tuberculosis (TB) |  |
| Hospice services |  |

F. 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. Plans may consult Section G of Chapter 4 of the Participant Handbook for examples.*] |  |
|  |  |
|  |  |

**G. 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
  + Ask for information in other formats (e.g., large print, braille, or 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 you can change your PCP at any time
  + Participate in Interdisciplinary Team 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 prior approval in an emergency
  + 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 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
* **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.

**H. 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*. You can also call <plan name> Participant Services.

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 or online at [icannys.org](http://icannys.org/). (TTY users call 711, then follow the prompts to dial 844-614-8800.)

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

**I. 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.
* [*Plans may also insert additional State-based resources for reporting fraud.*]