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.]
* [Plans should replace the reference to “Member Services” with the term the plan uses.]
* [Plans should note that any reference to a “Member Handbook” is also a reference to the Evidence of Coverage document.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a TTY/TDD number and days and hours of operation.]
* [Except in disclaimers, plans should reference Member Services’ contact information at the bottom of the page instead of repeating phone numbers and days and hours of operation throughout materials.]
* [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, 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 beneficiaries in a waiver program, in which case plans should indicate that State eligibility requirements may apply.]
* [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 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 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 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 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

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.

* [*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 Healthy Connections Medicaid services in one health plan. A <plan name> [care coordinator/care manager *(plan’s preference)*] 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/TDD numbers, days and hours of operation*]. 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 [*insert Member Services toll-free phone and TTY/TDD numbers, days and hours of operation*]. The call is free.
* [*Plans must also describe how members can make a standing request to get this document, now and in the future, in a language other than English or in an alternate format*.]

# 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 Medicare-Medicaid Plan?** | A Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Healthy Connections Medicaidto provide benefits of both programs to enrollees. It is for people with both Medicare and Healthy Connections 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/care managers *(plan’s preference)*] to help you manage all your providers and services. They all work together to provide the care you need. |
| **What is a <plan name>** [**care coordinator/care manager** *(plan’s preference)*]**?** | A <plan name> [care coordinator/care manager *(plan’s preference)*] 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 a variety of services and supports that help people meet their daily needs for assistance and improve the quality of their lives. LTSS are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, and making food. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. |
| **Will you get the same Medicare and Medicaid benefits in <plan name> that you get now?** | You will get your covered Medicare and Healthy Connections 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 Healthy Connections Medicaid benefits directly from <plan name>, but you may get some benefits the same way you do now, outside of the plan. This plan also offers services that are not usually covered by Medicare or Healthy Connections Medicaid.  When you enroll in <plan name>, you and your care team will work together to develop an Individualized Care Plan (ICP) to address your health and support needs. During this time, you can keep seeing the providers you see now for 180 days. You can also continue to get the same services and any that were authorized prior to your enrollment in <plan name>.  When you join our plan, if you are taking any Medicare Part D prescription drugs that <plan name> does not normally cover, you can get a temporary supply. We will help you get another drug or get an exception for <plan name> to cover your drug, if medically necessary. |
| **Can you go to the same doctors you see now?** | Often that is the case. If your providers (including doctors, therapists, and pharmacies) work with <plan name> and have a contract with us, you can keep going to them.   * Providers with an agreement with us are “in-network.” **You must use the providers in <plan name>’s network.** * If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of <plan name>'s plan. [*Plans may insert additional exceptions as appropriate.*]   To find out if your doctors are in the plan’s network, call Member Services or read <plan name>’s *Provider and Pharmacy Directory*.  If <plan name> is new for you, you can continue seeing the doctors you go to now for 180 days after you first enroll, even if they are out-of-network. If you need to continue seeing your out-of-network providers after your first 180 days in our plan, we will only cover that care if the provider enters a single case agreement with us. If you are getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact [*Plans must enter name of department or entity*] at <phone number>. |
| **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; *if plan is statewide, plan can enter* all Counties in] South Carolina. 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 health coverage. |
| **What is prior authorization?** | Prior authorization means that you must get approval from <plan name> before you can get a specific service or drug or see an out-of-network provider. <Plan name> may not cover the service or drug if you don’t get approval. If you need urgent or emergency care or out-of-area dialysis services, you don't need to get approval first.  See Chapter 3, [*plans may insert reference, as applicable*] of the *Member Handbook* to learn more about prior authorization. See the Benefits Chart in 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 see someone who 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, and you may be billed for these services. You don’t need a referral to see some specialists, such as women’s health specialists.  See 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. |
| **What is Extra Help?**  [If a 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 program 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/TDD number with or add contact information for Video Relay or other accessible technology.] |
| **Who should you contact if you have questions or need help? (continued on the next page)** | **If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call <plan name> Member Services at the number at the bottom of the page.**  Member Services also has free language interpreter services available for people who do not speak English. |
| **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.>] | |

# 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** [*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).*] |
| --- | --- | --- | --- |
| **You want to see a doctor** | Visits to treat an injury or illness | $0 |  |
| Wellness visits, such as a physical | $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) | [*Plans 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.  [Plans 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 see <plan name>’s *List of Covered* *Drugs* (Drug List) for more information.  [*Plans must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations and make clear that the cost sharing amount for these extended-day supplies is the same as for a one-month supply.*] |
| **You need drugs to treat your illness or condition (continued)** | Brand name drugs | [*Plans 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.  [Plans 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 see <plan name>’s *List of Covered Drugs* (Drug List) for more information.  [*Plans must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations and make clear that the cost sharing amount for these extended-day supplies is the same as for a one-month supply.*] |
| **You need drugs to treat your illness or condition (continued)** | Over-the-counter drugs | [*Plans should insert a single amount, multiple amounts, or minimum/maximum range.*] | There may be limitations on the types of drugs covered. Please see <plan name>’s *List of Covered Drugs* (Drug List) for more information. |
| Medicare Part B prescription drugs | $0 | Part B drugs include drugs given by your doctor in his or her office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs. |
| **You need therapy after a stroke or accident** | Occupational, physical, or speech therapy | $0 |  |
| Chiropractic services (only for manual manipulation for certain approved conditions) | $0 |  |
| **You need emergency care (This service is continued on the next page)** | Emergency room services | $0 | [*Plans must state that emergency room services must be provided OON and without prior authorization requirements.*] |
| Ambulance services | $0 |  |
| **You need emergency care (continued)** | 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 | Medicare-covered stays (for example, rehabilitation) require a prior authorization, while Healthy Connections Medicaid-covered stays (for example, long term skilled nursing facility (SNF) stays) only require a referral. |
| **You need eye care** | Treatment for eye injuries or diseases | $0 |  |
| Initial replacement of lens due to cataract surgery | $0 |  |
| **You need dental care** | Emergency medical procedures by oral surgeons | $0 |  |
| Dental procedures related to organ transplants, cancer, joint replacement, heart valve replacement, and trauma | $0 |  |
| **You need foot care** | Podiatry services | $0 |  |
| **You need hearing/auditory services** | Hearing screenings | $0 |  |
| **You have a chronic condition, such as diabetes or heart disease** | Services to help manage your disease | $0 |  |
| Diabetes supplies and services | $0 |  |
| Cardiac and pulmonary rehabilitation services | $0 |  |
| **You have a mental health condition** | Mental or behavioral health services | $0 |  |
| Partial hospitalization | $0 | [Network plans that do not have an in-network community mental health center may add: **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] |
| **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) (This service is continued on the next page)** | Wheelchairs | [List Medicare and Healthy Connections Medicaid-related copays, if any, for each DME item listed in this section according to your plan benefit package, not to exceed the allowed maximum of $3.40 – for example, “$0 or $3.40”] | [If copay amounts are different for Medicare and Medicaid-covered DME items, explain to which items any different copay amounts in this category would apply. For example, “The copay is $0 for <name of item> covered by Medicare. The copay is <amount, not to exceed $3.40> for <name of item> covered only by Healthy Connections Medicaid.”]  [Additionally, if applicable, plans can add: White canes for the blind are not covered.]  [*Plans can choose to explain the rental/ownership policy:* **Note:** Our plan will rent most DME items for you for a maximum of 10 months. [*Insert as applicable*: In some cases, it may be 13 months.] At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. See Chapter 3 of the *Member Handbook* for more information.] |
| **You need durable medical equipment (DME) (continued)** | Crutches | [List Medicare and Healthy Connections Medicaid-related copays, if any, for each DME item listed in this section according to your plan benefit package, not to exceed the allowed maximum of $3.40 – for example, “$0 or $3.40”] | [If copay amounts are different for Medicare and Medicaid-covered DME items, explain to which items any different copay amounts in this category would apply. For example, “The copay is $0 for <name of item> covered by Medicare. The copay is <amount, not to exceed $3.40> for <name of item> covered only by Healthy Connections Medicaid.”]  [Additionally, if applicable, plans can add: White canes for the blind are not covered.]  [*Plans can choose to explain the rental/ownership policy:* **Note**: Our plan will rent most DME items for you for a maximum of 10 months. [*Insert as applicable*: In some cases, it may be 13 months.] At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. See Chapter 3 of the *Member Handbook* for more information.] |
| **You need durable medical equipment (DME) (continued)** | IV infusion pumps | [List Medicare and Healthy Connections Medicaid-related copays, if any, for each DME item listed in this section according to your plan benefit package, not to exceed the allowed maximum of $3.40 – for example, “$0 or $3.40”] | [If copay amounts are different for Medicare and Medicaid-covered DME items, explain to which items any different copay amounts in this category would apply. For example, “The copay is $0 for <name of item> covered by Medicare. The copay is <amount, not to exceed $3.40> for <name of item> covered only by Healthy Connections Medicaid.”]  [Additionally, if applicable, plans can add: White canes for the blind are not covered.]  [*Plans can choose to explain the rental/ownership policy:* **Note**: Our plan will rent most DME items for you for a maximum of 10 months. [*Insert as applicable*: In some cases, it may be 13 months.] At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. See Chapter 3 of the *Member Handbook* for more information.] |
| **You need durable medical equipment (DME) (continued)** | Oxygen equipment and supplies | [List Medicare and Healthy Connections Medicaid-related copays, if any, for each DME item listed in this section according to your plan benefit package, not to exceed the allowed maximum of $3.40 – for example, “$0 or $3.40”] | [If copay amounts are different for Medicare and Medicaid-covered DME items, explain to which items any different copay amounts in this category would apply. For example, “The copay is $0 for <name of item> covered by Medicare. The copay is <amount, not to exceed $3.40> for <name of item> covered only by Healthy Connections Medicaid.”]  [Additionally, if applicable, plans can add: White canes for the blind are not covered.]  [*Plans can choose to explain the rental/ownership policy:* **Note**: Our plan will rent most DME items for you for a maximum of 10 months. [*Insert as applicable*: In some cases, it may be 13 months.] At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. See Chapter 3 of the *Member Handbook* for more information.] |
| **You need durable medical equipment (DME) (continued)** | Nebulizers | [List Medicare and Healthy Connections Medicaid-related copays, if any, for each DME item listed in this section according to your plan benefit package, not to exceed the allowed maximum of $3.40 – for example, “$0 or $3.40”] | [If copay amounts are different for Medicare and Medicaid-covered DME items, explain to which items any different copay amounts in this category would apply. For example, “The copay is $0 for <name of item> covered by Medicare. The copay is <amount, not to exceed $3.40> for <name of item> covered only by Healthy Connections Medicaid.”]  [Additionally, if applicable, plans can add: White canes for the blind are not covered.]  [*Plans can choose to explain the rental/ownership policy:* **Note**: Our plan will rent most DME items for you for a maximum of 10 months. [*Insert as applicable*: In some cases, it may be 13 months.] At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. See Chapter 3 of the *Member Handbook* for more information.] |
| **You need durable medical equipment (DME) (continued)** | Walkers | [List Medicare and Healthy Connections Medicaid-related copays, if any, for each DME item listed in this section according to your plan benefit package, not to exceed the allowed maximum of $3.40 – for example, “$0 or $3.40”] | [If copay amounts are different for Medicare and Medicaid-covered DME items, explain to which items any different copay amounts in this category would apply. For example, “The copay is $0 for <name of item> covered by Medicare. The copay is <amount, not to exceed $3.40> for <name of item> covered only by Healthy Connections Medicaid.”]  [Additionally, if applicable, plans can add: White canes for the blind are not covered.]  [*Plans can choose to explain the rental/ownership policy:* **Note**: Our plan will rent most DME items for you for a maximum of 10 months. [*Insert as applicable*: In some cases, it may be 13 months.] At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. See Chapter 3 of the *Member Handbook* for more information.] |
| **You need prosthetics** | Prosthetic devices | [List Medicare and Healthy Connections Medicaid-related copays, if any, according to your plan benefit package, not to exceed the allowed maximum of $3.40 – for example, “$0 or $3.40”] | [If copay amounts are different for Medicare and Medicaid-covered items, explain for what any different copay amounts in this category would apply. For example, “The copay is $0 for prosthetic devices covered by Medicare. The copay is <amount, not to exceed $3.40> for prosthetic devices covered only by Healthy Connections Medicaid.”] |
| **You need help living at home (This service is continued on the next page)** | Meals brought to your home | $0 | [*For all LTSS, insert the following if services are only available to beneficiaries on a waiver:* This service is provided only to members enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent waiver.] |
| Homemaker services, such as cleaning or housekeeping | $0 | [*For all LTSS, insert the following if services are only available to beneficiaries on a waiver:* These services are provided only to members enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent waiver.] |
| **You need help living at home (continued)** | Changes to your home, such as ramps and wheelchair access | $0 | [*For all LTSS, insert the following if services are only available to beneficiaries on a waiver:* These services are provided only to members enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent waiver.] |
| Personal care services  (You may be able to choose your own aide. Call Member Services for more information.) | $0 | [*For all LTSS, insert the following if services are only available to beneficiaries on a waiver:* This service is provided only to members enrolled in the Community Choices, HIV/AIDS, or Mechanical Ventilator Dependent waiver.] |
| Home health care services | [$0 or $3.30] | [If plan charges a $3.30 copay, insert: Home health care services covered by Medicare have a $0 copay. Home health services covered by Healthy Connections Medicaid have a $3.30 copay.] |
| Services to help you live on your own | [$0 or $3.30] | [If plan charges a $3.30 copay, insert: Home health care services covered by Medicare have a $0 copay. Home health services covered by Healthy Connections Medicaid have a $3.30 copay.] |
| **You need help living at home (continued)** | Adult day services or other support services | $0 |  |
| **You need a place to live with people available to help you** | Nursing home care | $0 or amount based on income | You must contribute toward the cost of this service when your income is more than an allowable amount. This contribution, known as the patient pay amount, is required only for those living in a nursing home. You will not need to pay if you are in the nursing home for short-term rehabilitation. |
| **Your caregiver needs some time off** | Respite care | $0 | Respite care can be provided in a Community Residential Care Facility (CRCF), a nursing facility, or at your home. Members are limited to 28 total days of respite care per year. Up to 28 days of respite care can be in a CRCF. Up to 14 days of respite care can be in a nursing facility. Up to 14 days of respite care can be in your home.  The type of care you are qualified to get will depend on your situation. [*Insert the following if services are only available to beneficiaries on a waiver:* CRCF respite care is available only to members enrolled in the Community Choices waiver. In-home respite care is available only to members enrolled in the Mechanical Ventilator Dependent waiver. Nursing facility respite care is available to members enrolled in either the Community Choices waiver or the Mechanical Ventilator Dependent waiver.] |
| **You need care for advanced illness or life-threatening injury** | Palliative care | $0 |  |
| **You need family planning services** | Birth control (condoms) | $0 | Family planning supplies are covered only with a prescription. |
| Family planning lab and diagnostic tests | $0 |  |
| Treatment for sexually transmitted infections (STIs) | $0 |  |

# Other services that <plan name> covers

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

| **Other services covered by <plan name>**  [*Insert special services offered by your program. This does not need to be a comprehensive list.*] | **Your costs for in-network providers**  [*Plans should include copays for listed services.*] |
| --- | --- |
| Education and Wellness Programs | $0 |
| End Stage Renal Disease Services | $0 |
| Infusion Services | $0 |
| Nursing Home Transition Services | $0 |
| Preventive Services | $0 |
| Services Provided at Federally Qualified Health Centers | $0 |
| Targeted Case Management | $0 |
| Telemedicine | $0 |

# Benefits 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 or Healthy Connections Medicaid.

| **Other services covered by Medicare or Healthy Connections Medicaid**  Please contact your [care coordinator/care manager *(plan’s preference)*] for more information. [*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. Plans may consult Section G of Chapter 4 of the Member Handbook for examples.*] | **Your costs**  [*Plans should include copays for listed services.*] |
| --- | --- |
| Some hospice care services | $0 |
| Dental services   * Diagnostics (oral evaluation and x-rays) * Preventive care (annual cleaning) * Restorative care (fillings) * Surgical care (extractions / removals) | $3.40  $3.40  $3.40  $3.40 |
| Non-emergency medical transportation | $0 |

# Services that <plan name>, Medicare, and Healthy Connections 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 Healthy Connections Medicaid**  [*Insert any excluded benefit categories. This does not need to be a comprehensive list. Plans may consult Section H of Chapter 4 of the Member Handbook for examples.*] | |
| --- | --- |
| Acupuncture | Naturopath services |
| Chiropractic care (except manual manipulation for certain approved conditions) | Non-prescription contraceptive supplies |
| Certain visual procedures such as LASIK | Orthopedic shoes (unless included with brace or for diabetic foot disease). Supportive devices for feet (except for diabetic foot disease) |
| Cosmetic surgery or cosmetic work | Personal items in your hospital or nursing home room |
| Dentures | Private room in hospital |
| Elective or voluntary enhancement procedures or services | Routine foot care (except for certain approved conditions) |
| Experimental medical and surgical treatments, items and drugs | Services not considered “reasonable and necessary” |
| Full-time nursing care in your home | Services provided to veterans in a VA facility |
| Hearing exams (except for certain approved conditions) | Surgical treatment for morbid obesity |

# 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 restraint or seclusion used as a means of coercion, discipline, convenience, a perceived safety measure, or retaliation.
* 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
* See 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
* See an out of network urgent or emergency care provider, when necessary
* **You have a right to confidentiality and privacy.** This includes the right to:
* Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
* 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 of the <plan name> *Member Handbook*. You can also call <plan name> Member Services.

[*Plans should include contact information for complaints, grievances, and appeals.*] There is a special ombudsman for this program called the Healthy Connections Prime Advocate. The Healthy Connections Prime Advocate does not work for us or Healthy Connections Medicaid. They can help you understand your rights and the appeal process, and they can help you with your appeal. You can reach the Healthy Connections Prime Advocate at 1-844-477-4632. TTY users should call 711.

# 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 at the bottom of the page and 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.*]