

Instructions to Health Plans

- ❖ *[Plans should replace the word “Medicaid” with the name of their Medicaid program, if appropriate.]*
- ❖ *[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.]*
- ❖ *[Plans should add or delete the categories in the “Services you may need” column to match State-specific benefit requirements.]*
- ❖ *[For the “Limitations, exceptions, & benefit information” column, plans should provide specific information about: need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out of pocket costs on services, and permissible OON services.]*
- ❖ *[For the “You need help living at home” category of services, indicate if services are only available to beneficiaries in a waiver program, in which case plans should indicate that State eligibility requirements may apply.]*
- ❖ *The multi-language insert is a document that contains language translated into multiple languages (Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese) regarding the availability of interpreter services. Regardless of the applicable CMS or State translation requirements, all plans must include the CMS created multi-language insert as specified in the Medicare Marketing Guidelines.*

Questions? Call <plan name> Member Services at **<toll-free number>** <days and hours of operation>. TTY/TDD: <toll-free number>. The call is free. **For more information**, visit **<web address>**. You can also call **<toll-free number>** to request a copy of the Member Handbook.

[<Marketing Material ID>]

This information is available for free in other languages. Please contact our customer service number at [insert customer service and TTY numbers, and hours of operation].

[This disclaimer must be placed in both English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]

Benefits, formulary, pharmacy and provider network, [and/or copayments] may change on January 1 of each year.



This is a summary of <plan name> benefits. <Plan’s legal or marketing name> is a health plan with a Medicare contract and a contract with <name of state Medicaid program>. It is for people with both Medicare and Medicaid.

[Plans may insert any additional eligibility criteria.]

Under <plan name> you can get all of your Medicare and Medicaid services in one health plan. A <plan name> care coordinator will help manage your health care needs. *[Plans should change “care coordinator” to the term used by the State and/or plan.]*

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.

Limitations, *[copayments,]* and restrictions may apply. For more information, call <plan name> Member Services or read <plan name> Member Handbook.

Frequent questions	Answers
<p>What is a health plan?</p>	<p>A health plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need. <i>Plans should change “care coordinator” to the term used by the State and/or plan.</i></p>
<p>What is a <plan name> “care coordinator?”</p>	<p>A <plan name> “care coordinator” 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. <i>[Plans should change “care coordinator” to the term used by the State and/or plan.]</i></p>
<p>What are long-term services and supports?</p>	<p>Long-term services and supports are services that help improve a long term medical condition. Most of these services help you stay in your home instead of going into a nursing home or hospital.</p>
<p>Will you get the same Medicare and Medicaid benefits in <plan name> that you get now?</p>	<p>If you are coming from another health plan, you might not get the same services that you get now. Call Member Services at <toll-free number> for more information.</p> <p><i>[Plans should add if applicable: You will get almost all of your covered Medicare and Medicaid benefits directly from <plan name>, but you may get some benefits the same way you do now, outside of the plan.]</i></p>
<p>Can you go to the same doctors you see now?</p>	<p>Maybe. If your providers (including doctors and pharmacies) work with <plan name> you can keep going to them. You must use the providers in <plan name>’s network. If you have an emergency, need services urgently, or if you need out-of-area dialysis services, you can use providers outside of <plan name>’s network. For more information, you can read <plan name> Member Handbook.</p> <p>To find out if your doctors are in the network, call Member Services, or read <plan name>’s Provider List.</p> <p>If <plan name> is new for you, you can continue seeing the doctors you go to now for <i>[Plans should discuss the State’s continuity of care requirement, e.g., for 90 days.]</i></p>

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Frequent questions	Answers
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: <i>[plans enter county or counties]</i> Counties <i>[enter * to denote partial county]</i> , <State>. You must live in <i>[plans enter this area or one of these areas]</i> to join the plan. <i>[Plans enter if applicable: * denotes partial county]</i>
Do you pay a monthly amount (also called a premium) under <plan name>?	No. Because you have Medicaid, you will not pay any monthly premiums for your health coverage. <i>[In the event a plan has a monthly premium that was approved by CMS and the State, plans should discuss it here.]</i>

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Common medical event	Services you may need <i>[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.]</i>	Your costs for in-network providers	Limitations, exceptions, & benefit information <i>[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).]</i>
You want to see a doctor	Visits to treat an injury or illness	[\$-] <i>[insert cost sharing where applicable]</i>	
	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	[\$-]	
	"Welcome to Medicare" preventive visit (one time only)	[\$-]	
You need medical tests	Lab tests, such as blood work	[\$-]	
	X-rays or other pictures, such as CAT scans	[\$-]	
	Screening tests, such as tests to check for cancer	[\$-]	

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<p>You need drugs to treat your illness or condition</p> <p><i>There may be limitations on the types of drugs covered. Please see <plan name>'s List of Covered Drugs (Formulary) for more information.</i></p>	<p>Generic drugs (no brand name)</p>	<p><i>[Plans should insert a single amount, multiple amounts, or a minimum/maximum range] for a [must be at least 30-day] supply.</i></p> <p>Copayments for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.</p>	<p><i>[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.]</i></p>

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	Brand name drugs	<p><i>[Plans should insert a single amount, multiple amounts, or a minimum/maximum range] for a [must be at least 30-day] supply.</i></p> <p>Copayments for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details</p>	
	Over-the-counter drugs	<p><i>[Plans should insert a single amount, multiple amounts, or a minimum/maximum range.]</i></p>	

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	Medicare Part B prescription drugs covered by <plan name> 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	[\$-]	
You need emergency care	Emergency room services		<i>[Plans must state that emergency room services must be provided OON and without prior authorization requirements.]</i>
	Ambulance services		<i>[Plans must state that ambulance services must be provided OON and without prior authorization requirements.]</i>
	Urgent care		<i>[Plans must state that urgent care services must be provided OON and without prior authorization requirements.]</i>

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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-up	[\$-]	
You need hearing/auditory services	Hearing screening	[\$-]	
	Hearing aids	[\$-]	
You 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 abuse problem	Substance abuse services	[\$-]	

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You need long term mental health services	Inpatient care for people who need mental health care	[\$-]	
You need durable medical equipment (DME)	Wheelchairs	[\$-]	
	Canes		
	Crutches		
	Walkers		
	Oxygen		

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You need help living at home	Meals brought to your home	[\$-]	<i>[For all LTSS, indicate if services are only available to beneficiaries on a waiver.]</i>
	Home services, such as cleaning or housekeeping	[\$-]	
	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	Assisted living or other housing services	[\$-]	

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extra help	Nursing home care	[\$-]	
Your caregiver needs some time off	Respite care	[\$-]	

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Other services <plan name> covers and services <plan name> does not cover:

Other services <plan name> covers (This is not a complete list. Call Member Services or read Member Handbook to find out about other covered services.)	
<i>[Insert special services offered by your program. This does not need to be a comprehensive list.]</i>	<i>[Plans should include co-pays for listed services.]</i>

Services <plan name> does <u>not</u> cover (This is not a complete list. Call Member Services to find out about other excluded services.)	
<i>[Insert any excluded benefit categories. This does not need to be a comprehensive list. However this should include benefit categories that are carved out of the plan.]</i>	

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If you have a complaint or think we should cover something we denied

If you have a complaint or think <plan name> should cover something we denied, call <plan name> at <toll-free number>. You may even be able to appeal our decision.

For questions about your rights, you can read <plan name> Member Handbook. You can also call <plan name> Member Services.

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

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

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