**Instructions to Health Plans**

* [Plans may add a cover page to the Summary of Benefits. Plans may include the marketing 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.*]
* [*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, 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.*]
* [*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 CMS or State translation requirements, all plans must include the CMS created multi-language insert as specified in the Medicare Marketing Guidelines.*]
* [*Plans may place a QR code on materials to provide an option for members to go online.*]

**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’s legal or marketing name> is a health plan that contracts with both Medicare and Ohio Medicaidto provide benefits of both programs to enrollees. It is for people with both Medicare and Medicaid.
* Under <plan name> you can get your Medicare and 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.
* Limitations [insert as appropriate: , co-pays] and restrictions may apply. For more information, call <plan name> Member Services or read the <plan name> Member Handbook.
* Benefits, List of Covered Drugs, [and] pharmacy and provider networks [, and/or copayments] may change from time to time throughout the year and on January 1 of each year.
* [*Plans that charge $0 copays for all Part D drugs may delete this disclaimer.*] Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.
* You can ask for this information in other formats, such as Braille or large print. Call <toll-free number>. The call is free.
* You can get this information for free in other languages. Call <toll-free number>. The call is free. [*The preceding sentence must be in 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.*]

**The following chart lists frequently asked questions.**

| **Frequently Asked Questions (FAQ)** | **Answers** |
| --- | --- |
| **What is a MyCare Ohio Plan?** | A MyCare Ohio Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care teams and 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 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. |
| **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 care team 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 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. 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. However, this rule does not apply in some cases:   * If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of <plan name>’s network. * You can see out-of-network Federally Qualified Health Centers, Rural Health Clinics, [and] qualified family planning providers listed in the Provider and Pharmacy Directory [*insert if the plan does not directly or indirectly contract with these entities and they are in the service area*: [and] certified nurse practitioners [and] certified nurse midwives]. * If you are receiving assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to receive the services from that out-of-network provider.   To find out if your doctors are in the plan’s network, call Member Services or read <plan name>’s Provider and Pharmacy Directory. |
| **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 [*plans should enter \* to denote partial county*], <State>. You must live in [*plans should enter* this area ***or*** one of these areas] to join the plan.  [*Plans enter if applicable:* \* denotes partial county] |
| **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. |
| **Will you need a referral from your PCP to see other doctors or specialists?** | Although you do not need approval (called a referral) from your Primary Care Provider (PCP) to see other providers, it is still important to contact your PCP before you see a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes. |
| **What is Extra Help?**  [If a plan is electing to reduce Part D co-payments to $0, the plan may delete this question.] | Extra Help is a Medicare program that helps reduce your prescription drug program costs  such as copays. 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?** [*Plans may modify the call-lines as appropriate*] | **If you have general questions or questions about our plan, services, billing, or member cards, please call <plan name> Member Services:**   |  |  | | --- | --- | | **CALL** | <Phone number(s)>  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/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.> |   **If you have questions about your health, please call the <nurse advice call line name>:**   |  |  | | --- | --- | | **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.> | |
| **Who should you contact if you have questions or need help? (continued)** [*Plans may modify the call-lines as appropriate*] | [*Insert if applicable:* **If you need immediate behavioral health services, please call the Behavioral Health Crisis Line:**   |  |  | | --- | --- | | **CALL** | <Phone number>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies*.] | | **TTY** | <TTY/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.>] | |

The following chart is a quick overview of what services you may need, your costs and rules about the benefits.

| **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 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).The information in this chart should be in line with the plan's approved plan benefit package (PBP).*] | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **You want to see 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 | | [$–] | | |  | |
| “Welcome to Medicare” preventive visit (one time only) | | [$–] | | |  | |
| **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 | | [$–] | | |  | |
| **You need drugs to treat your illness or condition** | | | Generic drugs (no brand name) | | [*Plans should insert a single amount, multiple amounts, or minimum/maximum range*] 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 receive. 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, multiple amounts, or minimum/maximum range*] for a [*must be at least 30-*day] supply.  [Plans may delete the following statement if they charge $0 for all brand name drugs.] Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details. | | | There may be limitations on the types of drugs covered. Please see <plan name>’s List of Covered Drugs (Drug List) for more information.  [*Plans must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations and make clear that the cost sharing amount for these extended-day supplies is the same as for a one-month supply.*] | |
| **You need drugs to treat your illness or condition**  (continued) | | Over-the-counter drugs | | [*Plans should insert a single amount, multiple amounts, or minimum/maximum range.*] | | | There may be limitations on the types of drugs covered. Please see <plan name>’s List of Covered Drugs (Drug List) for more information. | |
| Medicare Part B prescription drugs | | [$–] | | | 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 | | [$–] | | |  | |
| **You need emergency care** | | Emergency room services | | [$–] | | | [*Plans must state that they provide emergency room services OON and without prior authorization requirements.*] | |
| Ambulance services | | [$–] | | |  | |
| Urgent care | | [$–] | | | [*Plans must state that they provide urgent care services OON and without prior authorization requirements.*] | |
| **You need hospital care** | | Hospital stay | | [$–] | | |  | |
| Doctor or surgeon care | | [$–] | | |  | |
| **You need help getting better or have special health needs** | | Rehabilitation services | | [$–] | | |  | |
| Medical equipment at home | | [$–] | | |  | |
| 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** | | Services to help manage your disease | | [$–] | | |  | |
| Diabetes supplies and services | | [$–] | | |  | |
| **You have a mental health condition** | | Mental or behavioral health services | | [$–] | | |  | |
| **You have a substance abuse problem** | | Substance abuse services | | [$–] | | |  | |
| **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 | | [$–] | | |  | |
| Oxygen | | [$–] | | |  | |
| **You need help living at home** | | | Meals brought to your home | | [$–] | | | These services are available only if your need for long-term care has been determined by Ohio Medicaid.  You may be responsible for paying a “patient liability” for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. | |
| Home services, such as cleaning or housekeeping | | [$–] | | |
| Changes to your home, such as ramps and wheelchair access | | [$–] | | |
| Personal care assistant  (You may be able to employ your own assistant. Contact your Care Manager or Waiver Services Coordinator for more information.) | | [$–] | | |
| Community transition services | | [$–] | | |
| Home health care services | | [$–] | | |
| 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 | | [$–] | | These services are available only if your need for long-term care has been determined by Ohio Medicaid.  You may be responsible for paying a “patient liability” for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. | | |
| Nursing home care | | [$–] | |
| **Your caregiver needs some time off** | | | Respite care | | [$–] | | This service is available only if your need for long-term care has been determined by Ohio Medicaid.  You may be responsible for paying a “patient liability” for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. | | |

**Services that <plan name> does not cover**

[The services listed in the following chart are excluded from Medicare’s and Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits or are required to be covered by Medicaid or under a State’s demonstration, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may also add exclusions as needed.]

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

| **Services not covered by <plan name>** | |
| --- | --- |
| Services considered not “reasonable and necessary,” according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services. | Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it. |
| Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Experimental treatment and items are those that are not generally accepted by the medical community. | Chiropractic care, other than diagnostic x-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines. |
| Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it. | Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines. |
| A private room in a hospital, except when it is medically needed. | Acupuncture. |

**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 Chapter 8 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
  + The right to request information in other formats (e.g., audio CD‑ROM, large print, cassette, Braille)
  + The right to be free from any form of restraint or seclusion
  + The right not to 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 you can change your PCP at any time
  + To see a women’s health care provider without a referral
  + To get your covered services and drugs quickly
  + To know about all treatment options, no matter what they cost or whether they are covered
  + To refuse treatment, even if your doctor advises against it
  + To stop taking medicine
  + To 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 medical care timely
  + 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
  + You have the right to 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
  + The right to 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.

**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 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.*]

**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.
* Or, call the Ohio Attorney General's Office at 1-800-282-0515.