Instructions to Health Plans

* [*Plans may add a cover page to the Summary of Benefits. Plans may include the 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 number and days and hours of operation.*]
* [*Plans should replace references to “Member Services” with the term the plan uses.*]
* [*Plans may place a QR code on materials to provide an option for members to go online.*]
* [*Plans may change the orientation of the document from landscape to portrait.*]
* [*Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation. Plans must provide one phone number for both Medicare and Medicaid covered services if they are separate.*]
* [*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 out-of-network (OON) services, and applicable cost sharing (if different than in-plan cost sharing).*]
* [*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 on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, insert: This section is continued on the next page).*
* *Ensure plan-customized text is in plain language and complies with member reading level requirements.*
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples, as applicable.*
* *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Managed Long Term Services and Supports (MLTSS)).*
* *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 dialect in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*
* *Incorporate Americans with Disabilities Act (ADA) design principles in print and online materials, such as avoiding decorative and narrow font types and using 14-point font size for critical information (Headers, Summary of Benefits, Changes in Evidence of Coverage (also known as the Member Handbook)).*]

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 *Evidence of Coverage*.

[*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. Read the *Evidence of Coverage* for the full list of benefits. [*Plans must include information about how to contact Member Services to get an Evidence of Coverage and how to access the Evidence of Coverage on the plan’s website.*]

* [*Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V) and included in any state-specific guidance provided by New York’s State Department of Health (NYSDOH).*]
* [*As required at 42 CFR § 438.10(d)(2), all disclaimers and taglines that explain the availability of alternate formats using auxiliary aids and services or oral interpretation services and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a), must be in a conspicuously visible font.*]
* For more information about **Medicare**, you can read the *Medicare & You* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can access it online at the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or request a copy by calling 1-800- MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
* [*Plans may include either the current multi-language insert or provide a Notice of Availability. Plans that choose to use the current multi-language insert per 42 CFR §§ 422.2267(e)(31) and (e)(33) should include:* We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at <phone number>. Someone that speaks <language> can help you. This is a free service.[*This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state.*]

*OR*

*Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31) and 423.2267(e)(33), plans may choose to provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in <State> and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.*]

* You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.
* [*Plans that meet the Medicare 5 percent alternative language threshold or Medicaid required language threshold insert: This document is available for free in <languages that meet the threshold.>*]
* [*Plans also must simply describe:*
* *how they will request a member’s preferred language other than English and/or alternate format,*
* *how they will keep the member’s information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and*
* *how a member can change a standing request for preferred language and/or format or to update the member’s contact information, both critical to informing member of necessary steps to recertified Medicaid coverage.*]

# Frequently asked questions

The following table 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:* **(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 Medicaid Advantage Plus (MAP/HMO) + Dual Eligible Special Needs Plan (D-SNP) plan?** [*Plans specify the MAP and D-SNP names (if different).*] | Our MAP plan is a Health Maintenance Organization (HMO) aligned with a Dual Eligible (Medicaid and Medicare) Special Needs Plan (D-SNP). Our plan combines your Medicaid home care and long-term care services and your Medicare services. It combines your doctors, hospital, pharmacies, home care, nursing home care, behavioral health care (mental health and substance use/addiction services), and other health care providers into one coordinated health care system. It also has care coordinators to help you manage all of your providers and services. They all work together to provide the care you need. [*Plans should change “care coordinator” to the term used by the plan.*]  Our MAP plan is called <plan name>. |
| **Will I get the same Medicare and Medicaid benefits in <plan name> that I get now?** | If you are coming to <plan name> from Original Medicare or another Medicare plan, you may get benefits or services differently. You will get almost all of your covered Medicare and Medicaid benefits directly from <plan name>.  When you enroll in <plan name>, you and your Care Team will work together to develop an Individualized Plan of Care to address your health and support needs, reflecting your personal preferences and goals. If you are taking any Medicare Part D prescription drugs that <plan name> does not normally cover, you can get a temporary supply, and we will help you to transition to another drug or get an exception for <plan name> to cover your drug if medically necessary.  If you are taking any Medicare Part D prescription drugs that <plan name> does not normally cover, you can get a temporary supply and we will help you to transition to another drug or get an exception for <plan name> to cover your drug if medically necessary. For more information, call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> or at the numbers listed at the bottom of this page or at the numbers in the footer of this document]. |
| **Can I use the same health care providers I use now?** | That is often the case. If your providers (including doctors, therapists, pharmacies, and other health care providers) 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 behavioral health crisis * services or out-of-area dialysis services, you can use providers outside of <plan name>’s network. [*Plans may insert additional exceptions as appropriate.*]   To find out if your providers are in the plan’s network, call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or read <plan name>’s *Provider and Pharmacy Directory*. You can also visit our website at <URL> for the most current listing. [*Plans may insert additional language regarding the possibility for members’ out-of-network providers to contract with the plan.*]  If <plan name> is new for you, we will work with you to develop an Individualized Plan of Care (ICP) to address your needs. You can keep using the providers you use now for 90 days or until your ICP is completed. Further, members who enroll on or after January 1, 2025, can continue to use their same behavioral health providers for up to 24 months as part of a continuous episode of care. “Continuous Behavioral Health Episode of Care” means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the behavioral health benefit inclusion into MAP in the geographic service area in which services had been provided to an enrollee at least twice during the six months preceding January 1, 2025 by the same provider for the treatment of the same or related behavioral health condition. |
| **What is a Care Manager?** | A Care Manager is your main contact person at our plan. This person helps to manage all of your providers and services and make sure you get what you need.  Members may have a Care Manager who works for the Plan as well as a specialized Health Home/Health Home Plus Care Manager (refer to Section E. Benefits covered outside of <plan name>). |
| **What are Managed Long Term Services and Supports (MLTSS)?** | Managed Long Term Services and Supports (MLTSS) are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Often these services are provided at your home or in your community, but they could also be provided in a nursing home or hospital when necessary. MLTSS is available to members who meet certain clinical and financial requirements. |
| **What happens if I need a service but no one in <plan name>’s network can provide it?** | Most services will be provided by our network providers. If you need a service that cannot be provided within our network, such as due to shortage of staff with necessary expertise and/or availability to provide services, <plan name> will cover services provided by an out-of-network provider. |
| **Where is <plan name> available?** | The service area for this plan includes: <County name(s)> [*plans insert* County *or* Counties], <State>. You must live in [*plans insert:* this area ***or*** oneof these areas] to join the plan. |
| **What is prior authorization?** | Prior authorization means that you must get approval from <plan name> before <plan name> will cover a specific service, item, or drug or out-of-network provider. <Plan name> may not cover the service, item or drug if you don’t get prior approval. If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you don't need to get approval first. <Plan name> can provide you with a list of services or procedures that require you to get prior authorization from <plan name> before the service is provided.  Refer to **Chapter 3**, [*plans may insert reference, as applicable*] of the *Evidence of Coverage* to learn more about prior authorization. Refer to the Benefits Chart in **Chapter 4** of the *Evidence of Coverage* [*plans may insert reference, as applicable*] to learn which services require a prior authorization.  If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] for help. |
| **What is a referral?**  [*If a plan does not require referrals for any of its services, the plan may delete this question.*] | [*Plans may modify this section as needed*] A referral means that your primary care provider (PCP) must give you written approval before you can use specialists or other providers in the plan’s network. This can be done electronically however if you don’t get approval, <plan name> may not cover the services. You don’t need a referral to use certain specialists, such as women’s health specialists.  <Plan name>can provide you with a list of services that require you to get a referral from your PCP before the service is provided. For more information on when a referral is needed, call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or refer to **Chapter 3**, [*plans may insert reference, as applicable*] of the *Evidence of Coverage.* |
| **Do I pay a monthly amount (also called a premium) under <plan name>?** | No. Because you have Medical Assistance (Medicaid), you will not pay any monthly premiums for your health coverage. However, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medical Assistance (Medicaid) or another third party.[*If a plan has a monthly premium that was approved by the Centers for Medicare & Medicaid Services and the state, the plan should discuss it here.*] |
| **Do I pay a deductible as a member of <plan name>?** | No. You do not pay deductibles in <plan name>. |
| **What is the maximum out-of-pocket amount that I will pay for medical services as a member of <plan name>?** | There is no cost sharing (copays or deductibles) for medical services in <plan name>, so your annual out-of-pocket costs will be $0. |

# Overview of services

The following table is a quick overview of what services you may need 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. Plans may present multiple plan benefit packages (PBPs) in the same document by displaying the benefits in separate columns.* *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 members 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 referrals, need for prior authorization, utilization management restrictions for drugs, and permissible OON services.*] |
| --- | --- | --- | --- |
| You need hospital care | Inpatient hospital care | $0 | Except in an emergency, your health care provider must tell the plan of your hospital admission. |
| Outpatient hospital services (including outpatient treatment by a doctor or a surgeon) | $0 |  |
| Ambulatory surgical center (ASC) services | $0 |  |
| You want to use an outpatient health care provider (This service is continued on the next page) | Doctor visits (including visits to Primary Care Providers and specialists) | $0 |  |
| Visits to treat an injury or illness | $0 |  |
| You want to use a health care provider (continued) | Preventive care (care to keep you from getting sick, such as flu shots and other immunizations) | $0 |  |
| Wellness visits, such as a physical | $0 |  |
| “Welcome to Medicare” preventive visit (one time only) | $0 |  |
| You need emergency care | Emergency room services, including mental health emergencies at Comprehensive Psychiatric Emergency Programs (CPEPs) | $0 | You may use any emergency room or CPEP if you reasonably believe you need emergency care. You do not need prior authorization and you do not have to be in-network. Emergency room services are NOT covered outside of the U.S. and its territories except under limited circumstances. Contact the plan for details. |
| Urgent care | $0 | Urgent care is not emergency care. You do not need prior authorization and you do not have to be in-network. Urgent care is NOT covered outside the U.S. and its territories except under limited circumstances. Contact the plan for details. |
| You need medical tests | Lab tests, such as blood work | $0 |  |
| X-rays or other pictures, such as CAT scans | $0 |  |
| Screenings, such as tests to check for cancer | $0 |  |
| You need hearing/ auditory services | Hearing screenings (including routine hearing exams) | $0 |  |
| Hearing aids (as well as fittings and associated accessories and supplies) | $0 |  |
| You need dental care | Dental services (including, but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, dentures, and endodontic and periodontal care) | $0 |  |
| You need eye care (This service is continued on the next page) | Vision services (including annual eye exams) | $0 |  |
| Glasses or contact lenses | $0 |  |
| You need eye care (continued) | Other vision care (including diagnosis and treatment for diseases and conditions of the eye) | $0 |  |
| You have a mental health condition (This service is continued on the next page) | Inpatient mental health care (long-term mental health services, including inpatient services in a psychiatric hospital, general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), State Operated Addiction Treatment Center’s (ATC), Inpatient addition rehabilitation, Inpatient Medically Supervised Detox, or critical access hospital) | $0 |  |
| Adult outpatient mental health care  Continuing Day Treatment (CDT)  Partial hospitalization | $0 |  |
| You have a mental health condition (continued) | Adult outpatient rehabilitative mental health care  Assertive Community Treatment (ACT)  Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)  Personalized Recovery Oriented Services (PROS) | $0 |  |
| You have a mental health condition (continued) | Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements These are also known as Community Oriented Recovery and Empowerment (CORE) services. CORE services:  Psychosocial Rehabilitation (PSR)  Community Psychiatric Supports and Treatment (CPST)  Empowerment services – peer supports  Family Support and Training (FST) | $0 |  |
| Adult mental health crisis services  Comprehensive Psychiatric Emergency Program (CPEP)  Mobile Crisis and Telephonic Crisis Services  Crisis Residential Programs | $0 |  |
| You have a mental health condition (continued) | Outpatient mental health care (including, but not limited to, clinical counseling and therapy, peer support, psychosocial rehabilitation, medication management, family psychoeducation, and intensive outpatient models of care)  (**Note:** This is not a complete list of the plan’s expanded outpatient mental health services. Call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or read the *Evidence of Coverage* [*plans may insert reference, as applicable*] for more information.) | $0 | Services may be provided by any OMH licensed, designated, or approved provider agency, or a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care professional as allowed under applicable state laws. |
| You are having a mental health or substance use crisis | Mobile Crisis services (assessment by telephone or mobile crisis team response); short-term residential crisis stabilization (for mental health crises) | $0 | Any approved mobile crisis or licensed crisis residence provider in New York State. |
| You have a mental health condition or a substance use disorder | CORE Services (which are person-centered, recovery-oriented mobile behavioral health supports. CORE Services build skills and self-efficacy that promote and facilitate community participation and independence).  (**Note:** For more information about CORE Services and to determine whether you are eligible for them, call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or read the *Evidence of Coverage* [*plans may insert reference, as applicable*].) | $0 | CORE services are available to members who meet certain clinical requirements. Anyone can refer or self-refer to CORE Services. |
| You have a substance use disorder | Inpatient and outpatient substance use disorder treatment services (including, but not limited to, detoxification and withdrawal management, short-term residential services, residential treatment center services, and methadone Medication Assisted Treatment)  (**Note:** This is not a complete list of the plan’s expanded substance use disorder services. Call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or read the *Evidence of Coverage* [*plans may insert reference, as applicable*] for more information.) | $0 |  |
| You need a place to live with people available to help you | Skilled nursing care | $0 |  |
| Nursing home | $0 |  |
| Custodial care (long-term care in a Nursing Facility) | $0 | Services are covered for those who meet nursing facility level of care and whose rehabilitation goals have been met or discontinued with no plan to discharge to the community within 180 days of admission. |
| You need therapy after a stroke or accident | Occupational, physical, or speech therapy (outpatient or in-home) | $0 |  |
| You need help getting to health services | Emergency transportation | $0 |  |
| You need drugs to treat your illness or condition (This service is continued on the next page) | Medicare Part B prescription drugs (including those given by your provider in their office, some oral anti-cancer drugs, and some drugs used with certain medical equipment) | $0 | Read the *Evidence of Coverage* [*plans may insert reference, as applicable*] for more information on these drugs. |
| You need drugs to treat your illness or condition (continued) | Medicare Part D prescription drugs  [*Plans should insert tiers and a description of each tier. For example:*  Tier 1: Preferred Generic  Tier 2: Generic  Tier 3: Brand  Tier 4: Specialty] | [*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 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. Refer to <plan name>’s <formulary name (for example, *List of Covered Drugs*)> at <URL> for more information.  [*Plans may delete the following statement if they only have one coverage stage.*] Once you or others on your behalf pay $2,000 you have reached the catastrophic coverage stage and you pay $0 for all your Medicare drugs. Read the *Evidence of Coverage* for more information on this stage.  [*Cost sharing must be broken down by the tier number/name (e.g. Tier 1: Preferred Generic)*.]  <Plan name> may require you to first try one drug to treat your condition before it will cover another drug for that condition.  Some drugs have quantity limits.  Your provider must get prior authorization from <plan name> for certain drugs. |
| You need drugs to treat your illness or condition (continued) |  |  | You must use certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, <formulary name (for example, *List of Covered Drugs*)>, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on [www.medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).  [*Plans must indicate if extended-day supplies are available at retail and/or mail order pharmacy locations.*] |
| Over-the-counter (OTC) drugs | $0 | There may be limitations on the types of drugs covered. Please refer to <plan name>’s *List of Covered Drugs* (*Drug List*) for more information. |
| You need foot care | Podiatry services (including routine exams) | $0 |  |
| Orthotic services | $0 |  |
| You need durable medical equipment (DME) or supplies | Wheelchairs, nebulizers, crutches, roll about knee walkers, walkers, and oxygen equipment and supplies, for example  (**Note:** This is not a complete list of covered DME or supplies. Call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or read the *Evidence of Coverage* [*plans may insert reference, as applicable*] for more information.) | $0 |  |
| You need interpreter services | Spoken language interpreter | $0 |  |
| Sign language interpreter | $0 |  |
| Other covered services (This service is continued on the next page) | Acupuncture | $0 |  |
| Plan Care coordination | $0 |  |
| Chiropractic services | $0 |  |
| Other covered services (continued) | Diabetic supplies | $0 |  |
| Early and Periodic Screening Diagnosis and Treatment (EPSDT) (including preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services) | $0 | EPSDT is for members under 21 years of age. |
| Family planning | $0 | Family planning services furnished by out-of-network providers are covered directly by Medicaid fee-for-service. |
| Hospice care | $0 |  |
| Mammograms | $0 |  |
| Other covered services (continued) | Managed Long Term Services and Supports (MLTSS) (including, but not limited to, assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); and social adult day care) | $0 | MLTSS provides services for members that need the level of care typically provided in a Nursing Facility, and allows them to get necessary care in a residential or community setting.  MLTSS is available to all members; specific service authorization, including amount, is indicated in the member’s individualized approved Plan of Care. |
| Medical day care (including preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting) | $0 | Medical day care is provided to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. |
| Other covered services (continued) | Personal Care Assistance (PCA) (assistance with daily activities such as bathing, dressing, using the bathroom, shopping, cooking, including health-related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care) | $0 |  |
| Prosthetic services | $0 |  |
| Services to help manage your disease | $0 |  |

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read <plan name>’s *Evidence of Coverage*. If you have questions, you can also call <plan name> Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

# Additional services <plan name> covers

This is not a complete list. Call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] or read the *Evidence of Coverage* to find out about other covered services. [*Plans insert any supplemental benefits or other services offered that are not part of the basic NY MAP D-SNP benefit package. This does not need to be a comprehensive list.*]

| **Additional services <plan name> covers** | **Your costs** |
| --- | --- |
|  | $0 |
|  | $0 |
|  | $0 |

# Benefits covered outside of <plan name>

This is not a complete list. Call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] to find out about other services not covered by <plan name> but available through Medicaid fee-for-service.

| **Other services covered directly by Medicaid fee-for-service** | **Your costs** [*Plans should include any applicable copays for listed services.*] |
| --- | --- |
| CSS (Community Support Services) | $0 |
| Health Home (HH) and Health Home Plus (HH+) Care Management services |  |
| Certified Community Behavioral Health Clinics (CCBHC) |  |
| Crisis Intervention Services for Youth ages 18-20 |  |
| Non-emergency Medical Transportation |  |

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

The following services are not covered by our plan. This is not a complete list. Call Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document] to find out about other excluded services.

| **Services <plan name>, Medicare, and Medicaid do not cover** | |
| --- | --- |
| [*Insert any excluded benefit categories. This does not need to be a comprehensive list. Plans may consult* ***Chapter 4*** *of the Evidence of Coverage for examples.*] | Personal and Comfort items |
| Cosmetic surgery if not medically necessary | Services of a provider that is not part of the plan, unless the plan sends you to that provider |
|  |  |
|  |  |

# Your rights and responsibilities as a member of the plan

As a member of <plan name>, you have certain rights concerning your health care. You also have certain responsibilities to the health care providers who are taking care of you. Regardless of your health condition, you cannot be refused medically necessary treatment. You can 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, read the *Evidence of Coverage.*

**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, color, religion, creed, sex (including sex stereotypes and gender identity), age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation.
* Ask for and get information in other formats (for example, large print, braille, audio) free of charge
* 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
  + Apply your rights freely 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, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
  + <Plan name>
  + Description of the services we cover
  + How to get services
  + How much services will cost you
  + Names of health care providers and Care Managers
  + Your rights and responsibilities
* **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  + Choose a primary care provider (PCP) and change your PCP at any time during the year. You can call <phone number> if you want to change your PCP.
  + Use a women’s health care provider without a referral
  + Get your covered services and drugs quickly
  + Know about all treatment options, no matter what they cost or whether they are covered
  + Refuse treatment as far as the law allows, even if your health care provider advises against it
  + Stop taking medicine, even if your health care provider advises against it
  + Ask for a second opinion about any health care that your PCP or your Care Team advises you to have. <Plan name> will pay for the cost of your second opinion visit.
  + Make your health care wishes known in an advance directive
* 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, other providers, and your health plan. Call <phone number> if you need help with this service
* Have your *Evidence of Coverage* and any printed materials from <plan name> translated into your primary language, and/or have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
* Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation
* **You have the right to emergency and urgent care when you need it**. This means you have the right to:
* Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval
* Use an out-of-network urgent or emergency care provider, when necessary
* **You have a right to confidentiality and privacy.** This includes the right to:
  + Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  + Have your personal health information kept private. No personal health information will be released to anyone without your consent, unless required by law.
  + Have privacy during treatment
* **You have the right to make complaints about your covered services or care.** This includes the right to:
  + Access an easy process to voice your concerns, and to expect follow-up by <plan name>
  + File a complaint or grievance against us or our providers. You also have the right to appeal certain decisions made by us or our providers
* Ask for a State Appeal (State Fair Hearing)
  + Get a detailed reason why services were denied

**Your responsibilities include, but are not limited to, the following**:

* **You have a responsibility to treat others with respect, fairness, and dignity.** You should:
  + Treat your health care providers with dignity and respect
  + Keep appointments, be on time, and call in advance if you’re going to be late or have to cancel
* **You have the responsibility to give information about you and your health.** You should:
  + Tell your health care provider your health complaints clearly and provide as much information as possible
  + Tell your health care provider about yourself and your health history
  + Tell your health care provider that you are a <plan name> member
  + Talk to your PCP, Care Manager, or other appropriate person about seeking the services of a specialist before you go to a hospital (except in cases of emergency)
  + Tell your PCP, Care Manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment
  + Notify <plan name> Member Services if there are any changes in your personal information, such as your address or phone number
* **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
  + Learn about your health problems and any recommended treatment, and consider the treatment before it’s performed
  + Partner with your Care Team and work out treatment plans and goals together
  + Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health
* **You have the responsibility to obtain your services from <plan name>.** You should:
  + Get all your health care from <plan name>, except in cases of emergency, urgent care, behavioral health crisis services, out-of-area dialysis services, or family planning services, unless <plan name> provides a prior authorization for out-of-network care
  + Not allow anyone else to use your <plan name> Member ID Card to obtain healthcare services
  + Notify <plan name> when you believe that someone has purposely misused <plan name> benefits or services

For more information about your rights, you can read <plan name>’s *Evidence of Coverage*. If you have questions, you can also call <plan name> Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

# 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 can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read **Chapter 8** of <plan name>’s *Evidence of Coverage*. You can also call <plan name> Member Services [*plans may insert reference:* at <toll-free phone and TTY numbers> *or* at the numbers listed at the bottom of this page *or* at the numbers in the footer of this document].

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

# What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, contact us.

* Call us at <plan name> Member Services. Phone numbers are [*plans may insert reference:* on the cover of this summary *or* <toll-free phone and TTY numbers> *or* the numbers listed at the bottom of this page *or* the numbers in the footer of this document].
* Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
* Or, call the New York State Medicaid Fraud Hotline 1–877–87 FRAUD.
* [*Plans may also insert additional state-based resources for reporting fraud*.]

[*This is the recommended format for the back cover of the Summary of Benefits. Plans may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the contact information.* *Plans may modify the call lines as appropriate.*]

| **If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, call <plan name> Member Services:** |
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| <toll-free phone number(s)>  Calls to this number are free. <days and hours of operation, including information on the use of alternative technologies>.  Member Services also has free language interpreter services available for non-English speakers. |
| *<*TTY number*>*  [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]  Calls to this number are free. *<*days and hours of operation*>.* |
| [*Insert if applicable:* **If you have questions about your health:**   * Call your primary care provider (PCP). Follow your PCP’s instructions for getting care when the office is closed. * If your PCP’s office is closed, you can also call <plan’s Nurse Line Name>. A nurse will listen to your problem and tell you how to get care. (Example: [convenience care,] urgent care, emergency room). The numbers for the <plan’s Nurse Line Name> are: |
| *<*phone number(s*)*>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies.*]  <Plan name> also has free language interpreter services available for non-English speakers. |
| *<*TTY number>  Calls to this number are [*Insert if applicable:* not] free. <Days and hours of operation.>] |
| [*Insert if applicable:* **If** **you need immediate behavioral health care, call the <Behavioral Health Crisis Line name>:** |
| *<*phone number(s)>  Calls to this number are free. <Days and hours of operation.> [*Include information on the use of alternative technologies.*]  <Plan name> also has free language interpreter services available for non-English speakers. |
| *<*TTY number>  Calls to this number are [*Insert if applicable:* not] free. <Days and hours of operation.>] |