**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.]
* [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 dialects in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*]

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.*]

**Table of Contents**

[A. Disclaimers 4](#_Toc167349826)

[B. Frequently asked questions 6](#_Toc167349827)

[C. Overview of services 10](#_Toc167349828)

[D. Additional services <plan name> covers 22](#_Toc167349829)

[E. Benefits covered outside of <plan name> 22](#_Toc167349830)

[F. Services not covered by <plan name> (exclusions) 23](#_Toc167349831)

[G. Your rights and responsibilities as a member of the plan 24](#_Toc167349832)

[H. How to file a complaint or appeal a denied service 28](#_Toc167349833)

[I. What to do if you suspect fraud 28](#_Toc167349834)

1. 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 Jersey’s Division of Medical Assistance and Health Services (DMAHS)*.]
* [*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.*]
* 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. [*The text of this bullet point must be in print no smaller than 18 point font.*]
* [*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 New Jersey and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.*]

* [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.]

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.

1. 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*: **(continued from previous page)**. *Plans should also be aware that the flow of FAQ from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other FAQ as needed. Additionally, plans should maintain consistency of table formatting, borders, and color scheme throughout after adding plan-customized information*.]

[Plans may add a maximum of two additional FAQs to this section. For example, plans may add an FAQ giving additional information about their specific plan. Answers must be kept brief, consistent with the pre-populated responses in the template.]

| **Frequently Asked Questions (FAQ)** | **Answers** |
| --- | --- |
| **What is a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)?** | A NJ Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) is a managed health care option for NJ FamilyCare members with Medicare. A NJ FIDE SNP covers all of your Medicare, NJ FamilyCare (Medicaid) and prescription drug benefits, including Medicare Part D, and extra benefits, in one health plan, with one Member Identification (ID) Card, and no copays for medical services or prescription drugs. A FIDE SNP coordinates all of your care.  If you join a FIDE SNP, you do not lose any of your NJ FamilyCare, Managed Long Term Services and Supports (MLTSS), or Medicare benefits. Every service you have with NJ FamilyCare and Medicare is still available, along with access to some additional services.  To be eligible to enroll in a FIDE SNP in New Jersey, you must be entitled to Medicare Parts A and B and eligible for full NJ FamilyCare benefits. You must also live in the plan’s “service area” (the counties where that plan is offered). The counties that make up <plan name>’s service area are listed on page <page number> of this document. |
| **Will I get the same Medicare and NJ FamilyCare 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 NJ FamilyCare 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. |
| **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 using 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 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 <Internet address> 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 to address your needs. You can keep using the providers you use now for 90 days or until your individualized Plan of Care is completed. |
| **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. |
| **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, <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 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. |
| **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 approval before you can use specialists or other providers in the plan’s network. 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 section reference, as applicable*] of the *Evidence of Coverage.* |
| **Do I pay a monthly amount (also called a premium) under <plan name>?** | No. You will not pay any monthly premiums to <plan name>for your health coverage.  Additionally, Medicaid will pay your Medicare Part B premium for you. |
| **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 for medical services in <plan name>, so your annual out-of-pocket costs will be $0. |

1. Overview of services

The following chart 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 a health care provider** | Doctor visits (including visits to Primary Care Providers and specialists) | $0 |  |
| Visits to treat an injury or illness | $0 |  |
| 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 (This service is continued on the next page)** | Emergency room services | $0 | You may use any emergency room 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. |
| **You need emergency care (continued)** | Urgently needed services | $0 | Urgently needed services are not emergency care. You do not need prior authorization and you do not have to be in-network. Urgently needed services are 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** | Vision services (including annual eye exams) | $0 |  |
| Glasses or contact lenses | $0 |  |
| 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), or critical access hospital) | $0 | All members are covered by the plan for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. |
| **You have a mental health condition (continued)** | Outpatient mental health care (including, but not limited to, adult mental health rehabilitation in supervised group homes and apartments, clinic and hospital services, partial care, and medication management)  (**Note:** This is not a complete list of the plan’s expanded outpatient mental health services. Call Member Services [*plans may insert reference for reader, for example:* 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 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 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 for reader, for example:* 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 care | $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 | $0 |  |
| **You need help getting to health services** | Ambulance services | $0 |  |
| 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. |
| Medicare Part D prescription drugs  Tier <tier number>: Generic and brand name drugs | $0 | 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.  <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 to 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. |
| Diabetes medications | $0 |  |
| **You need foot care** | Podiatry services (including routine exams) | $0 |  |
| Orthotic services | $0 |  |
| **You need durable medical equipment (DME) or supplies** | Wheelchairs, nebulizers, crutches, rollabout 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 for reader, for example:* 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 |  |
| Care coordination | $0 |  |
| **Other covered services (continued)** | Chiropractic services | $0 |  |
| 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); vehicle modifications; social adult day care; and non-medical transportation) | $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 members who meet certain clinical requirements. |
| 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. |
| Personal Care Assistance (PCA) (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 |  |
| **Other covered services (continued)** | 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].

1. Additional services <plan name> covers

This is not a complete list. Call Member Services [*plans may insert reference for reader, for example:* 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 NJ FIDE SNP benefit package. This does not need to be a comprehensive list.*]

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

1. 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** |
| --- | --- |
| Non-Emergency (Routine) Transportation (including mobile assistance vehicles (MAVs)); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage) | $0 |
| Targeted case management (chronic mental illness) | $0 |
| Behavioral Health Home (Care Management) | $0 |
| PACT (Program in Assertive Community Treatment) | $0 |
| CSS (Community Support Services) | $0 |
| Psychiatric Emergency Services (PES)/Affiliated Emergency Services (AES) | $0 |

1. Services not covered by <plan name> (exclusions)

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 not covered by <plan name> (exclusions)** |
| --- |
| Services not considered “reasonable and necessary” according to standards of Medicare and NJ FamilyCare |
| Experimental medical and surgical treatments, items, or drugs unless covered by Medicare or under a Medicare-approved clinical study |
| Surgical treatment for morbid obesity except when medically necessary |
| Elective or voluntary enhancement procedures |
| Cosmetic surgery or other cosmetic work unless required criteria are met |
| LASIK surgery |

1. 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>
  + 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 use 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 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 using 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, 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].

1. 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 9 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*.]

1. 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.
* You can also contact New Jersey’s Medicaid Fraud Division (of the Office of the State Comptroller) by calling 1-609-292-1272. Calls to this number are free.
* [*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:** |
| --- |
| *<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. |
| *Insert <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.>] |