Instructions to Health Plans

* [*If plans do not use the term care team,” plans should replace it consistently throughout with the term the plan uses.*]
* [*Plans may add a cover page to the Summary of Benefits. Plans may include the Material ID only on the cover page.*]
* [*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.*]
* [*Plans should add or delete the categories in the “Services you may need” column to match state-specific benefit requirements.*]
* [*For the “Limitations, exceptions, & benefit information” column, plans should provide specific information about need for referrals, need for prior authorization, utilization management restrictions for drugs, maximum out-of-pocket costs on services, permissible out-of-network (OON) services, and applicable cost sharing (if different than in-plan cost sharing).*]
* *[Plans may place a QR code on materials to provide an option for members to go online.*]
* [*Wherever possible, plans are encouraged to adopt 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 the Table of Contents or any 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, Long-term Services and Supports (LTSS) or low income subsidy (LIS)).
* Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.
* Avoid separating a heading or subheading from the text that follows when paginating the model.
* Use universal symbols or commonly understood pictorials.
* Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.
* Consider using regionally appropriate terms or common dialects in translated models.
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*]

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*.

[*After adding plan-customized information, plans must update the Table of Contents as needed to reflect the correct page number where each section begins.*]

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# Disclaimers

Exclamation Point

White exclamation point appears in blue box at top of page with short description of the Summary of Benefits.This is a summary of health services covered by <plan name> for <date>. This is only a summary. Please 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 the State of Wisconsin.*]
* [*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. It has a summary of Medicare benefits, rights, and protections and answers to the most frequently asked questions about Medicare. You can get it at the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or 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.
* For more information about Family Care Partnership, you can check the State of Wisconsin Department of Health Services website [www.dhs.wisconsin.gov/familycare/fcp-index.htm](https://www.dhs.wisconsin.gov/familycare/fcp-index.htm) or contact ForwardHealth Member Services at 800-362-3002, TTY: 711 (Wisconsin Relay)
* [*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.*]

# Frequently asked questions (FAQ)

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

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

| **Frequently Asked Questions** | **Answers** |
| --- | --- |
| **What is a <plan name> Family Care Partnership Fully Integrated Dual Eligible (FIDE) SNP?** | [*Insert a description of the program including whether the plan covers both Medicare and Medicaid, prescription drug benefits, eligibility criteria such as living in the plan service area or age, Medicaid eligibility, general information on copays, information on care team, and information on Long Term Services and Supports (LTSS).*] |
| **Will I get the same Medicare and Medicaidbenefits in <plan name> that I get now?** | You will get most of your covered Medicare and Medicaid benefits directly from <plan name>. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change based on your needs, and your doctor and care team assessment. You may also get other benefits outside of your health plan the same way you do now, directly from [*plans insert as applicable:* a state or county agency, specialty mental health and substance use disorder services, or regional center services.]  When you enroll in <plan name>, you and your care team will work together to develop a care plan 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. For more information, call <Member Services *or* your care team> [*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 go to the same doctors I use now?** | This is often the case. If your providers (including doctors, hospitals, 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.” Network providers participate in our plan. That means they accept members of our plan and provide services our plan covers. **You must use the providers in <plan name>’s network.** If you use providers or pharmacies that are not in our network, the plan may not pay for these services or drugs. * If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of <plan name>’s plan. [*Plans may insert additional exceptions as appropriate.*] * [*Insert information about any continuity of care requirements. Example language includes*: If you are currently under treatment with a provider that is out of <plan name>’s network, or have an established relationship with a provider that is out of <plan name>’s network, call <Member Services *or* your care team> to check about staying connected*.*]   To find out if your providers are in the plan’s network, call <Member Services *or* your care team> [*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 [*insert either Provider and Pharmacy Directory or Provider Directory*] on the plan’s website at <URL>. [*Plans may insert additional language regarding the possibility for member’s out-of-network providers to contract with the plan.*]  If <plan name> is new for you, we will work with you to develop [*plans insert term used, such as:* an Individualized Plan of Care *or* a care plan] to address your needs. |
| **What is a <plan name> care team?** | A <plan name> care team are the professionals and friends of family you decide will help you get the services you need. |
| **What are Long-term Services and Supports (LTSS)?** | [*Adjust language as applicable:* Long-term Services and Supports are help for people who need assistance to do everyday tasks like bathing, toileting, 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. In some cases, a county or other agency may administer these services, and your care team will work with that agency.] |
| **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 pay for the cost of 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], Wisconsin. 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.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 more information about whether the plan is available where you live.] |
| **What is prior authorization?** | Prior authorization means an approval from <plan name> to seek services outside of our network or to get services not routinely covered by our network **before** you get the services. <Plan name> may not cover the service, procedure, item, or drug if you don’t get prior authorization.  **If you** **need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first**. <Plan name> can provide you or your provider 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 *or* your care team> [*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 [*insert:* primary care provider (PCP) ***or*** care team] must give you approval to go to someone that is not your PCP. A referral is different than a prior authorization. If you don’t get a referral from your [*insert:* PCP ***or*** care team], <plan name> may not cover the services. <Plan name>can provide you with a list of services that require you to get a referral from your [*insert:* PCP ***or*** care team] before the service is provided.  Refer to the *Evidence of Coverage* [*plans may insert section reference, as applicable*] to learn more about when you will need to get a referral from your [*insert:* PCP *or* care team]. |
| **Do I pay a monthly amount (also called a premium) under <plan name>?** | No. Because you have Medicaid you will not pay any monthly premiums for your health coverage. However, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by 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 for medical services in <plan name>, so your annual out-of-pocket costs will be $0. |

# List of covered services

The following table is a quick overview of what services you may need, your costs, and rules about the benefits. [*Plans should list the following text under a health need or concern title if its services continue on the next page*: **(continued on the next page)**. *Plans should also enter the health need or concern title with* **(continued)***below the title at the top of the following page*. *When adding or deleting health needs or concerns or services or when populating the chart in this section, plans should maintain consistency of formatting, borders, and color scheme throughout. The chart is properly formatted in the model to serve as an example for plans.*]

| Health need or concern | 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, maximum out-of-pocket costs on services, and permissible OON services and applicable cost sharing (if different than in-network cost sharing).*] |
| --- | --- | --- | --- |
| You need hospital care | Inpatient hospital stay | [$0] | [*Insert or modify as applicable:* Except in an emergency, your health care provider must tell the plan of your hospital admission.] |
| Outpatient hospital services, including observation | [$0] |  |
| Ambulatory surgical center (ASC) services | [$0] |  |
| Doctor or surgeon care | [$0] |  |
| You want a doctor (continued on next page) | Visits to treat an injury or illness | [$0] |  |
| Care to keep you from getting sick, such as flu shots and screenings to check for cancer | [$0] |  |
| You want a doctor (continued) | Wellness visits, such as a physical | [$0] |  |
| “Welcome to Medicare” (preventive visit one time only) | [$0] |  |
| Specialist care | [$0] |  |
| You need emergency care | Emergency room services | [$0] | [*Plans must state that emergency room services must be provided OON and without prior authorization requirements.*] |
| Urgent care | [$0] | [*Plans must state that urgent care services must be provided OON and without prior authorization requirements.*] |
| You need medical tests | Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs) | [$0] |  |
| Lab tests and diagnostic procedures, such as blood work | [$0] |  |
| You need hearing/auditory services | Hearing screenings | [$0] |  |
| Hearing aids | [$0] |  |
| You need dental care | Dental check-ups and preventive care | [$0] |  |
| Restorative and emergency dental care | [$0] | [*Plans must include link to information about Medicaid dental benefits and providers as applicable*] |
| You need eye care | Eye exams | [$0] |  |
| Glasses or contact lenses | [$0] |  |
| Other vision care | [$0] |  |
| You need mental health services | Mental health services | [$0] | [*Update as applicable:* *Plans must include both Medicare and Medicaid managed care benefits for mental health, with references to info below about specialty mental health.*] |
| Inpatient and outpatient care and community-based services for people who need mental health services | [$0] | [*Update as applicable: Plans must include both Medicare and Medicaid managed care benefits for mental health, with references to info below about specialty mental health.*] |
| You need a substance use disorder services | Substance use disorder services | [$0] | [*Update as applicable: Plans must include both Medicare and Medicaid managed care benefits, with references below on how to access county substance use disorder services.*] |
| You need a place to live with people available to help you | Skilled nursing care | [$0] |  |
| Nursing home care | [$0] |  |
| Adult Foster Care and Group Adult Foster Care | [$0] |  |
| 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] |  |
| Transportation to medical appointments and services | [$0] |  |
| You need drugs to treat your illness or condition (continued on the next page) | Medicare Part B prescription drugs | [$0] | Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Evidence of Coverage* for more information on these drugs. |
| 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. Please refer to <plan name>’s *List of Covered Drugs* (*Drug List*) for more information.  [*Plans may delete the following statement if they only have one coverage stage.*] Once you or others on your behalf pay <insert TrOOP amount> 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)*.]  [*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) | [*Plans insert as applicable:* Over-the-counter (OTC) drugs] | [*Plans should insert a single amount, multiple amounts, or minimum/maximum range*.] | 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 help getting better or have special health needs | Rehabilitation services | [$0] |  |
| Medical equipment for home care | [$0] |  |
| Dialysis services | [$0] |  |
| You need foot care | Podiatry services | [$0] |  |
| Orthotic services | [$0] |  |
| You need durable medical equipment (DME)  Note: This is not a complete list of covered DME. For a complete list, contact <Member Services *or* your care team> or refer to Chapter 4 of the *Evidence of Coverage*. | Wheelchairs, crutches, and walkers | [$0] |  |
| Nebulizers | [$0] |  |
| Oxygen equipment and supplies | [$0] |  |
| You need help living at home (continued on next page) | Home health services | [$0] |  |
| Home services, such as cleaning or housekeeping, or home modifications such as grab bars | [$0] | [*Plans should include information about how to get community based Medicaid supports like home modifications.*] |
| [*Update as applicable:* Adult day health, Community Based Adult Services (CBAS), or other support services] | [$0] | [*Plans should include information on how to qualify for these or similar support services available.*] |
| Day habilitation services | [$0] |  |
| You need help living at home (continued) | Services to help you live on your own (home health care services or personal care attendant services) | [$0] | [*Update as applicable: Plans should include information about Home Health as well as reference info below about Medicaid Community Supports.*] |
| Additional services [*Plans are encouraged to insert other special services they offer that are not already included in the chart. This does not need to be a comprehensive list.*] | Chiropractic services | [$0] |  |
| Diabetes supplies and services | [$0] |  |
| Prosthetic services | [$0] |  |
| Radiation therapy | [$0] |  |
| Services to help manage your disease | [$0] |  |

The above summary of benefits is provided for informational purposes only and is not a complete list of benefits. For a complete list and more information about your benefits, you can read the <plan name> *Evidence of Coverage*. If you don’t have an *Evidence of Coverage*, call <plan name> <Member Services *or* your care team> [*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 get one. If you have questions, you can also call <Member Services *or* your care team> or visit <URL>.

# Benefits covered outside of <plan name>

There are some services that you can get that are not covered by <plan name> but are covered by Medicare, Medicaid, or a State or county agency. This is not a complete list. Call <Member Services *or* your care team> [*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 these services.

| **Other services covered by Medicare, Medicaid, or a State Agency** | **Your costs** |
| --- | --- |
| [*Insert services covered outside the plan by Medicare fee-for-service and/or Medicaid fee-for-service, as appropriate. This does not need to be a comprehensive list, but at a minimum should include specialty mental health and substance use disorder services, waiver programs, home and community supports, and regional center services, including all services listed in Appendix B of the Family Care Partnership D-SNP contract.*] | [*Plans should include copays for listed services.*] |
| Certain hospice care services covered outside of <plan name> | $0 |
| Psychosocial rehabilitation |  |
| Targeted case management |  |
| Rest home room and board |  |

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

This is not a complete list. Call <Member Services *or* your care team> [*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*.] |  |
|  |  |
|  |  |

# Your rights as a member of the plan

As a member of <plan name>, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the *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 medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance
* Get information in other languages and formats (for example, large print, braille, or audio) free of charge
* Be free from any form of physical restraint or seclusion
* **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 language and format you can understand. This includes the right to get information on:
* Description of the services we cover
* How to get services
* How much services will cost you
* Names of health care providers and team
* 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
* 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, 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. <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 health care providers 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 authorization in an emergency
* 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
* Have privacy during treatment
* 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
* File a complaint with State of Wisconsin Department of Health Services ForwardHealth Member Services at <800-362-3002, TTY: 711 (Wisconsin Relay)>. The <insert plan name> website <URL> [plans insert as applicable: has complaint forms, and instructions available online.]
* Appeal certain decisions made by State of Wisconsin Department of Health Services or our providers
* Ask for a State Hearing
* Get a detailed reason for why services were denied

For more information about your rights, you can read the *Evidence of Coverage*. If you have questions, you can call <plan name> <Member Services *or* your care team> [*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].

You can also call the special Independent Ombudsman for people who have Medicare and Medicaid. For members ages 18 to 59, contact: Disability Rights Wisconsin, Toll Free: 800-928-8778 and TTY: 711 (Wisconsin Relay). For members age 60 and older, contact: Wisconsin Board on Aging and Long Term Care, Toll Free: 800-815-0015 and TTY: 711 (Wisconsin Relay).

# 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 <Member Services *or* your care team> [*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]. You may be able to appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of the *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 plan contact information for complaints, grievances, appeals, as well as the IMR and complaint process.*]

# What to do if you suspect fraud

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

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

* Call us at <plan name> <Member Services *or* your care team>. 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 the ForwardHealth Customer Service Center at <800-362-3002>. TTY users may call <711 (Wisconsin Relay)>.
* 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 Wisconsin Department of Health Services Fraud Hotline at 1-877-865-3432. TTY users may call 711 (Wisconsin Relay).

[*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, please 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. |
| *<*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, please 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.>] |