<Plan name>

Member Handbook

[*Before use and under the appropriate, State-specific material code(s), plans must upload in HPMS either (1) a standalone ANOC and a standalone EOC (Member Handbook) or (2) a combined ANOC/EOC (Member Handbook). Plans should only use the combined ANOC/EOC (Member Handbook) material code if they are sending enrollees a combined document.* *Plans should not use the combined ANOC/EOC code in conjunction with either the ANOC standalone code or the EOC standalone code. Plans should only upload the documents once. Plans should work with their marketing reviewers to withdraw any duplicate material submitted in error. Plans must enter Actual Mail Dates (AMDs) for all materials in accordance with CMS requirements as detailed in the “Update Material Link/Function” section of the Marketing Review Users Guide in HPMS. Note that plans must enter AMD information for ANOC/EOC (Member Handbook) mailings only for mailings to current members. Plans should not enter AMD information for October 1, November 1, or December 1 effective enrollment dates or for January 1 effective enrollment dates for any new members.*]

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.*]

[*Plans may add a front cover to the Member Handbook that contains information such as the plan name, Member Handbook title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Marketing Material ID.*]

[Plans must revise “Medicaid” references to “MassHealth” throughout the handbook.]

[Where the template uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to behavioral health services, long-term services and supports, and/or home and community-based services as applicable.]

[Where the template uses “Care Coordinator,” plans may replace this term for the name they use for this role.]

[Plans may change references to “member,” “customer,” or “beneficiary” to whatever term they prefer.]

[Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY/TDD number and days and hours of operation.]

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross-reference throughout the handbook.]

[Plans may include an overall Table of Contents for the Member Handbook if they so choose.]

**<start date> – <end date>**

**Your Health and Drug Coverage under the <plan name> Medicare-Medicaid Plan**

[Optional: Insert beneficiary name.]  
[Optional: Insert beneficiary address.]

This handbook tells you about your coverage under <plan name> through <end date>. It explains health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports provide the care you need at home and may reduce your chances of going to a nursing facility or hospital. **This is an important legal document. Please keep it in a safe place.**

<Plan name> (Medicare Medicaid Plan) is offered by [insert sponsor name]. When this *Member Handbook* says “we,” “us,” or “our,” it means [insert sponsor name]. When it says “the plan” or “our plan,” it means <plan name>*.*

**Disclaimers**

[Insert plan’s legal or marketing name] is a health plan that contracts with both Medicare and MassHealth to provide benefits of both programs to enrollees.

Coverage under <plan name> qualifies as minimum essential coverage (MEC). It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement for MEC.

Limitations [insert as appropriate: , copays,] and restrictions may apply. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have <plan name> pay for your services.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits [and/or copays]may change on January 1 of each year.

[*Plans that charge $0 copays for all Part D drugs may delete this disclaimer.*] Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.

[Plans may insert additional disclaimers or state-required statements, including state-required disclaimer language, here.]

If you speak [*insert language of the disclaimer*], language assistance services, free of charge, are available to you. Call [insert Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation]. The call is free. [*This disclaimer must be included in Spanish and any other* non-English languages that meet the Medicare and/or state thresholds for translation*.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY/TDD numbers>, <days and hours of operation>*.* The call is free.

[Plans must also describe how members can make a standing request to get this document, now and in the future, in a language other than English or in an alternate format.]

Chapter 1: Getting started as a member

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# Welcome to <plan name>

<Plan name> is a One Care: MassHealth plus Medicare plan. A One Care plan is made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other health care providers. In a One Care plan, a Care Coordinator will work with you to develop a plan that meets your specific health needs. A Care Coordinator will also help you manage all your providers, services, and supports. They all work together to give you the care you need.

<Plan name> was approved by the Commonwealth of Massachusetts and CMS (the Centers for Medicare & Medicaid Services) to provide you services as part of One Care.

One Care is a pilot program run by Massachusetts and the federal government to provide better health care for people who have both Medicare and MassHealth (Medicaid). This pilot program lets the state and federal government test new ways to improve how you get your Medicare and MassHealth health care services.

[Plan can include language about itself.]

# What are Medicare and MassHealth?

## Medicare

Medicare is the federal health insurance program for:

* people 65 years of age or older;
* some people under age 65 with certain disabilities; and

people with end-stage renal disease (kidney failure).

## MassHealth

MassHealth is the name of the Massachusetts Medicaid program. MassHealth is run by the federal government and the state. MassHealth helps people with limited incomes and resources pay for long-term services and supports and medical costs. It also covers extra services and drugs that are not covered by Medicare.

Each state has its own Medicaid plan. That means that each state decides what counts as income and resources, and who qualifies for Medicaid in that state. Each state also decides which services are covered, and what those services cost. States can decide how to run their own Medicaid programs as long as they follow the federal rules.

[Plans may add language indicating that Medicaid approves their plan each year, if applicable.] Medicare and Massachusetts must approve <plan name> each year. You can get Medicare and Medicaid services through our plan as long as:

* you are eligible to participate in One Care;
* we still offer the plan in your county; and

Medicare and the Massachusetts approve the plan.

Even if our plan stops operating, your eligibility for Medicare and MassHealth services will stay the same.

# What are the advantages of this One Care Plan?

You will now get all your covered Medicare and MassHealth services from <plan name>. This includes prescription drugs. You do not have to pay extra to join this health plan.

<Plan name> will help make your Medicare and MassHealth benefits work better together and work better for you. Here are some of the advantages of having <plan name> as your health plan.

* You will have a Care Team made up of people you choose. A Care Team is a group of people that will get to know your needs and work with you to help you create and carry out a Personal Care Plan. Your Care Team will talk with you about the services that are right for you.
* You will have a Care Coordinator who will work with you, the health plan, and your care team to make sure you get the care you need.
* If you need long-term services and supports (LTSS), you will also have an Independent Living and Long-Term Services and Supports Coordinator (also known as a Long Term Supports (LTS) Coordinator). Long-term services and supports are for people who need help doing everyday tasks like taking a bath, getting dressed, making food, and taking medicine,
  + An LTS Coordinator will help you find and get the right LTSS services.
  + Both the Care Coordinator and LTS Coordinator work with your Care Team to make sure you get the care you need.
* You will be able to take charge of your own care with help from your Care Team and Care Coordinator.
* The Care Team and Care Coordinator will work with you to come up with a Personal Care Plan specially designed to meet your health needs. They will help you get the right services and organize your care. The Care Team will be in charge of managing the services you need. For example:
  + Your Care Team will make sure that your doctors know about all your medicines so they can reduce any side effects.
  + Your Care Team will make sure that all your doctors and other providers see your test results.
  + Your Care Team will help you get appointments with doctors and other providers who can help you with any disability accommodations you need.

# What is <plan name>’s service area?

[Insert plan service area here or within an appendix. Include a map if one is available.

Use county name only if approved for entire county, for example: Our service area includes these counties in <State>: <counties>.

For partially approved counties, use county name plus ZIP code, for example: Our service area includes parts of <county> County with the following ZIP codes: <ZIP codes>.

If needed, plans may insert more than one row to describe their service area.]

<Plan name> is only for people who live in our service area.

If you move outside of our service area, you cannot stay in this plan.

# What makes you eligible to be a plan member?

You are eligible for our plan as long as you:

* live in our service area; ***and***
* have both Medicare Part A and Medicare Part B and are eligible for Part D; ***and***
* are eligible for MassHealth Standard or MassHealth CommonHealth and [insert language as appropriate under terms of state contract]; ***and***
* are a United States citizen or are lawfully present in the United States; ***and***
* are not enrolled in a MassHealth Home and Community-based Services (HCBS) waiver; ***and***
* have no other health insurance.

# What to expect when you first join a health plan

**If <plan name> is a new plan for you**, you can keep seeing your doctors and getting your current services for 90 days, or until your care plan is complete. If you are taking any Medicare Part D prescription drugs when you join our plan, you can get a temporary supply. We will help you to transition to another drug if necessary.

Within the first 90 days of your enrollment in the plan, you will get an in-person health assessment. After the assessment, you and your Care Team will work together to develop your Personal Care Plan.

[Plans should discuss the process for the comprehensive assessment– who performs it, who will contact the beneficiary, etc.]

After the first 90 days, you will need to see doctors and other providers in the <plan name> network. *A network provider is a provider who works with the health plan.* See Chapter 3 [plans may insert reference, as applicable] for more information on getting care from provider networks.

# What is a Personal Care Plan?

After your health assessment, your care team will meet with you to talk about the health services you need and want. Together, you and your care team will make a care plan.

A *Personal Care Plan* lists the services you will get, and also how you will get them. A Personal Care Plan includes the services that you need for your physical and mental health care and long-term services and supports. The providers you see and medications you take will be a part of your Personal Care Plan. You will be able to list your health, independent living and recovery goals, as well as any concerns you may have and the steps needed to address them.

Your One Care plan will work with you at all times and will work with your family, friends, and advocates if you choose. You will be at the center of the process of making your Personal Care Plan.

Every year, your care team will work with you to update your care plan in case there is a change in the health services you need and want. Your personal care plan can also be updated as your goals or needs change throughout the year.

# Does <plan name> have a monthly plan premium?

You will not pay any monthly premiums to <plan name>for your health coverage.

If you pay a premium to MassHealth for CommonHealth, you must continue to pay the premium to MassHealth to keep your coverage.

Members who enter a nursing facility may have to pay a Patient Paid Amount to keep your MassHealth coverage. The Patient Paid Amount is the member's contribution to the cost of care in the facility. MassHealth will send you a detailed notice should you be expected to pay a Patient Paid Amount.

# About the Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all   
of the rules in this document. If you think we have done something that goes against   
these rules, you may be able to appeal, or challenge, our action. For information about   
how to appeal, see Chapter 9 [plans may insert reference, as applicable], or call   
1-800-MEDICARE (1-800-633-4227).

The contract is in effect for the months you are enrolled in <plan name> between <start date> and <end date>.

# What other information will you get from us?

You should have already gotten a <plan name> Member ID Card, [insert if applicable: information about how to access] the *Provider and Pharmacy Directory*, [*plans that limit DME brands and manufacturers insert*: a *List of Durable Medical Equipment*,] and the *List of Covered Drugs*.

## Your <plan name> Member ID Card

Under our plan, you will have just one card for your Medicare and MassHealth services, including long-term services and supports and prescription drugs. You must show this card when you get any services or prescriptions. Here is a sample card to show you what yours will look like:

[Insert picture of front and back of Member ID Card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).]

If your card is damaged, lost, or stolen, call Member Services <toll-free number> right away. We will send you a new card.

As long as you are a member of our plan, you should not use your red, white, and blue Medicare card or your MassHealth card to get services. **Keep those cards in a safe place, in case you need them later.** If you show your Medicare card instead of your <plan name> Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. See Chapter 7 [plans may insert reference, as applicable] to see what to do if you get a bill from a provider.

## *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the <plan name> network. While you are a member of our plan, you must use network providers to get covered services.

* You can ask for a new *Provider and Pharmacy Directory* at any time by calling Member Services at <toll-free number>. You can also see the *Provider and Pharmacy Directory* at <web address> or download it from this website. [Plans may modify language if the Provider and Pharmacy Directory will be sent annually.]

[Plans must add information describing the information available in the directory.]

### What are “network providers”?

* [Plans should modify this paragraph to include all services covered by the state, including long-term supports and services.] <Plan name>’s network providers include:
  + Doctors, nurses, and other health care professionals that you can go to as a member of our plan;
  + Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; and
  + Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or MassHealth.

Network providers have agreed to accept payment from our plan [plans with cost sharing, insert: and cost sharing] for covered services as payment in full. You will not have to pay anything more for covered services.

### What are “network pharmacies”?

* Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.

You *must* fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at <toll-free number> for more information or to get a copy of the *Provider and Pharmacy Directory.*

[*Plans that limit DME brands and manufacturers insert the following section (for more information about this requirement, refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.):*

## List of Durable Medical Equipment (DME)

With this Member Handbook, we sent you <plan name>’s List of Durable Medical Equipment. This list tells you the brands and makers of durable medical equipment that we cover. The most recent list of brands, makers, and suppliers is also available on our website at <website address>.]

## List of Covered Drugs

The plan has a *List of Covered Drugs* or *Formulary*. We call it the “Drug List” for short. It tells which prescription drugs are covered by <plan name>.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5 [plans may insert reference, as applicable] for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List. To get the most up-to-date information about which drugs are covered, visit <web address> or call <toll-free number>.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* is also available when you ask for one. To get a copy, please contact Member Services.

# How can you keep your membership record up to date?

[In the heading and this section, plans should substitute the name used for this file if it is different from “membership record.”]

You can keep your membership record up to date by letting us know when your information changes.

The plan’s network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get** and how much they will cost you. Because of this, it is very important that you help us keep your information up to date.

Let us know if any of these situations applies to you:

* If you have any changes to your name, address, or phone number
* If you get other health insurance coverage like coverage from your employer, your spouse’s employer, or workers’ compensation
* If you have any liability claims, such as claims from an automobile accident
* If you are admitted to a nursing facility or hospital
* If you get care in an out-of-area or out-of-network hospital or emergency room
* If there’s a change in who your caregiver (or anyone else responsible for you) is

If you are part of a clinical research study

If any information changes, please let us know by calling Member Services at <toll-free number>.

[Plans that allow members to update this information online may describe that option here.]

## Do we keep your personal health information private?

Yes. Laws require us to keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see [plans may insert reference, as applicable].