<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 should follow the instructions in the Medicare Marketing Guidelines and state-specific demonstration plan marketing guidance regarding use of the standardized plan type (Medicare-Medicaid Plan) following the plan name. Plans should not use ICO when referring to themselves. Plans should use health plan or MI Health Link where appropriate.*]

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

[Plans may change references of “member” to “enrollee” as they choose.]

[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.*]

**<start date> – <end date>**

## Your Health and Drug Coverage under the <plan name>

[Plans: Revise this language to reflect that the organization is providing both Michigan Medicaid and Medicare covered benefits, when applicable.]

[Optional: Insert member name.]  
[Optional: Insert member 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 supports and services. Long term supports and services help you stay at home instead of going to a nursing home or hospital. **This is an important legal document. Please keep it in a safe place.**

This 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>*. [Plans can also change this language in this paragraph to make it appropriate for particular plan’s marketing name.]*

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 all* non-English languages that meet the Medicare and/or state thresholds for translation. If the plan doesn’t meet either the Medicare or state thresholds for translation of written materials, the disclaimer should not be included.]

You can get this document for free in other formats, such as large print, braille, or audio. Call [insert Member Services toll-free phone and TTY/TDD numbers, and 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.]

## Disclaimers

<Plan’s legal or marketing name> is a health plan that contracts with both Medicare and Michigan Medicaid 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, restrictions, and patient pay amounts may apply. 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. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook.

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 may change on January 1 of each year.

[Plans may insert additional disclaimers or state-required statements, including state-required disclaimer language, here.] **Chapter 1: Getting started as a member**

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# Welcome to <plan name>

<Plan name> is a Medicare-Medicaid Plan. A *Medicare-Medicaid Plan* is an organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

<Plan name> was approved by the State of Michigan and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MI Health Link program.

MI Health Link is a program jointly run by Michigan and the federal government to provide better health care for people who have both Medicare and Michigan Medicaid. Under this program, the state and federal government want to test new ways to improve how you get your Medicare and Michigan Medicaid health care services.

[Plan can include language about itself.]

# What are Medicare and Michigan Medicaid?

## Medicare

Medicare is the federal health insurance program for the following people:

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

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

## Michigan Medicaid

Michigan Medicaid is a program run by the federal government and the State of Michigan that helps people with limited incomes and resources pay for long term supports and services and medical costs. It also covers extra services and drugs not covered by Medicare.

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

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

* you are eligible to participate
* we choose to offer the plan, and

Medicare and the State of Michigan approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Michigan Medicaid services will not be affected.

# What are the advantages of this plan?

You will now get all your covered Medicare and Michigan Medicaid services from <plan name>, including prescription drugs. You do not pay extra to join this health plan.

<Plan name> will help make your Medicare and Michigan Medicaid benefits work better together and work better for you. Some of the advantages include:

* You will not pay a deductible or copay when you get services from a provider or pharmacy in our health plan’s provider network.
* You will have your own Care Coordinator who will ask you about your health care needs and choices and work with you to create a personal care plan based on your goals.
* Your Care Coordinator will help you get what you need, when you need it. This person will answer your questions and make sure that your health care issues get the attention they deserve.
* If you qualify, you will have access to home and community-based supports and services to help you live independently.
* [*Plans may insert additional advantages as they choose*.]

# 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.]

Only people who live in our service area can get <plan name>.

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 the following are true:

* you live in our service area, ***and***
* you have Medicare Part A, Part B, and Part D, ***and***
* you are eligible for full Michigan Medicaid benefits, ***and***
* you are a United States citizen or are lawfully present in the United States, ***and***

you are not already enrolled in hospice, **and**

* + to learn more about the hospice benefit please look at Chapter 4 of the Member Handbook

you are not enrolled in the MI Choice waiver program or the Program of All-inclusive Care for the Elderly (PACE). If you are enrolled in either of these programs, you need to disenroll before enrolling in the MI Health Link program through <plan name>.

# What to expect when you first join our plan

You will get a Level I Assessment within the first 45 days of joining our plan. [Plans should discuss the process for the Level I Assessment – who performs it, who will contact the member, etc.]

**If <plan name> is new for you**, you can keep getting services and seeing the doctors and other providers you go to now for at least 90 days from your enrollment start date. If you get services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the Prepaid Inpatient Health Plan (PIHP), you will be able to get services and see the doctors and providers you go to now for up to 180 days from your enrollment start date. Your Care Coordinator will work with you to choose new providers and arrange services within this time period if your current provider is not part of <plan name>’s provider network. Call <plan name> for information about nursing home services.

After [plans should describe continuity of care requirements], 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.

# What is a care plan?

A *care plan* is the plan for what supports and services you will get and how you will get them.

After your Level I Assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make a care plan.

Every year, and when the health services you need and want change, your care team will work with you to update your care plan.

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

No.

# 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] a *Provider and Pharmacy Directory*, [*plans that limit DME brands and manufacturers insert*: a *List of Durable Medical Equipment*,] and a *List of Covered Drugs*.

Your <plan name> Member ID Card

Under our plan, you will have one card for your Medicare and Michigan Medicaid services, including long term supports and services and prescriptions. You must show this card when you get any services or prescriptions. Here’s 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 right away and we will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Michigan Medicaid 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. There are some exceptions when you first join our plan. (See page <page number>).

* You can ask for an annual *Provider and Pharmacy Directory* by calling Member Services at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>. You can also see the *Provider and Pharmacy Directory* at <MMP 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 Michigan Medicaid.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

### 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.

Except during an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Member Services at <toll-free phone and TTY/TDD numbers>, <days and hours of operation> for more information. Both Member Services and <plan name>’s website can give you the most up-to-date information about changes in our network pharmacies and providers.

[*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 DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at <MMP web address>.]

List of Covered Drugs

The plan has a *List of Covered Drugs*. 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, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit <MMP web address> or call <phone 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.

[*Plans may insert other methods that members can get their* EOB*.*]

# 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 it will cost you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

* If you have any changes to your name, your address, or your phone number
* If you have any changes in any other health insurance coverage, such as 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 home or hospital
* If you get care in an out-of-area or out-of-network hospital or emergency room
* If your caregiver or anyone responsible for you changes

If you are part of a clinical research study

If any information changes, please let us know by calling Member Services at <toll-free phone and TTY/TDD numbers>, <days and hours of operation>.

[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 that we 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].