**<Plan name> *Member Handbook***

* [*Before use and under the appropriate, State-specific material code(s), plans must upload in HPMS only (1) a standalone ANOC and (2) a standalone EOC (Member Handbook). Plans should work with their marketing reviewers to withdraw any duplicate material submitted in error. Plans must enter Actual Mail Dates (AMDs) for ANOCs in accordance with CMS requirements as detailed in the “Update AMD/ Beneficiary Link/Function” section of the Marketing Review Users Guide in HPMS. Note that plans must enter AMD information for ANOC mailings only for mailings to current members. Plans should not enter ANOC 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* [*www.hhs.gov/civil-rights/for-individuals/section-1557*](http://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 Material ID.*]
* [*Plans should change “MMP” to any State-specific name for health plans.*]
* [*Where the template uses “medical care,” “medical services,” or “health care services” to explain services provided, plans may revise and/or add references to home and community-based services.*]
* [*Plans may change references to “member,” “customer,” or “beneficiary” to whatever term they prefer.*]
* [*Where the template instructs inclusion of a phone number, plans should include a TTY 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.*]
* [*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, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert:* **This section is continued on the next page***).*
* *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
* *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.*
* *Consider producing translated models in large print.*]

**<start date> – <end date>**

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

[*Optional: Insert member name.*]

[*Optional: Insert member address.*]

***Member Handbook* Introduction**

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 home and community-based waiver services (also called long-term services and supports). Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

**This is an important legal document. Please keep it in a safe place.**

This plan, <plan name>, is offered by [*insert legal entity name*]. When this *Member Handbook* says “we,” “us,” or “our,” it means [*insert legal entity name*]. When it says “the plan” or “our plan,” it means <plan name>.

ATTENTION: If you speak [*insert language of the disclaimer*], language services, free of charge, are available to you. Call [*insert Member Services toll-free phone and TTY numbers, 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 [*insert Member Services toll-free phone and TTY numbers, days and hours of operation*]. The call is free.

If you have any problems reading or understanding this handbook or any other <plan name> information, please contact Member Services. We can explain the information or provide the information in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing impaired, special help can be provided.

[*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.*]

[*Plans must include an overall Table of Contents for the Member Handbook after the Member Handbook Introduction and before the Member Handbook Disclaimers.*]

**Disclaimers**

* [*Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]
* [*Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.*]
* Coverage under <plan name> is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.

**Chapter 1: Getting started as a member**

**Introduction**

This chapter includes information about <plan name>, a health plan that covers all your Medicare and Medicaid services. It also tells you what to expect as a member and what other information you will get from <plan name>. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

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# Welcome to <plan name>

<Plan name>, offered by <legal entity name>, is a Medicare-Medicaid Plan. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care managers 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 Ohio Department of Medicaid (ODM) and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MyCare Ohio program.

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

[*Plan can include language about itself.*]

# Information about Medicare and Medicaid

You have both Medicare and Medicaid. <Plan name> will make sure these programs work together to get you the care you need.

## B1. 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).

## B2. Medicaid

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

Each state decides:

* what counts as income and resources,
* who qualifies,
* what services are covered, and
* the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Ohio Medicaid must approve <plan name> each year. You can get Medicare and Medicaid services through our plan as long as:

* we choose to offer the plan, and
* Medicare and Ohio Medicaid approve the plan.

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

# Advantages of this plan

You will now get all your covered Medicare and 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 Medicaid benefits work better together and work better for you. Some of the advantages include:

* You will be able to work with **one** health plan for **all** of your health insurance needs.
* You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
* You will have a care manager. This is a person who works with you, with <plan name>, and with your care providers to make sure you get the care you need. He or she will be a member of your care team.
* You will be able to direct your own care with help from your care team and care manager.
* The care team and care manager will work with you to come up with a care plan specifically designed to meet your needs. The care team will be in charge of coordinating the services you need. This means, for example:
* Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
* Your care team will make sure your test results are shared with all your doctors and other providers.

# <Plan name>’s service area

<Plan name> is available only to people who live in our service area. To keep being a member of our plan, you must keep living in this service area.

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

*Use county name, for example:* Our service area includes these counties in Ohio: <counties>*.*

*If needed, plans may insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that is easy to understand*.]

If you move, you must report the move to your County Department of Job and Family Services office. If you move to a new state, you will need to apply for Medicaid in the new state. See Chapter 8 [*plans may* *insert reference, as applicable*] for more information about the effects of moving out of our service area.

# What makes you eligible to be a plan member

You are eligible for membership in our plan as long as:

* you live in our service area; **and**
* you have Medicare Parts A, B and D; **and**
* you have full Medicaid coverage; **and**
* you are a United States citizen or are lawfully present in the United States, **and**
* you are 18 years of age or older at time of enrollment.

Even if you meet the above criteria, you are not eligible to enroll in <plan name> if you:

* have other third party creditable health care coverage; **or**
* have intellectual or other developmental disabilities and get services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID); **or**
* are enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

Additionally, you have the choice to disenroll from <plan name> if you are a member of a federally recognized Indian tribe.

If you believe that you meet any of the above criteria and should not be enrolled, please contact Member Services for assistance.

# What to expect when you first join a health plan

When you first join the plan**,** you will get a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. [*Plans should discuss the process for the health care needs assessment – who performs it, who will contact the member, etc.*]

**If <plan name> is new for you,** you can keep seeing the doctors you go to now for at least 90 days after you enroll. Also, if you already had previous approval to get services, our plan will honor the approval until you get the services. This is called a “transition period.” The New Member Letter included with your *Member Handbook* has more information on the transition periods. If you are on the MyCare Ohio Waiver, your *Member Handbook* Supplement or “Waiver Handbook” also has more information on transition periods for waiver services.

After the transition period, you will need to see doctors and other providers in the <plan name> network for most services. 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. Member Services can help you find a network provider.

If you are currently seeing a provider that is not a network provider or if you already have services approved and/or scheduled, it is important that you call Member Services right away so we can arrange the services and avoid any billing issues.

# Your care plan

Your care plan is the plan for what health services you will get and how you will get them.

After your health care needs 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 your care plan.

Your care team will continuously work with you to update your care plan to address the health services you need and want.

# <Plan name> monthly plan premium

<Plan name> does not have a monthly plan premium.

# 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 <page number>. You can also call Member Services at <toll-free number> or Medicare at 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at <phone number>. You can also see the *Member Handbook* at <web address> or download it from this website. [Plans may modify language if the Member Handbook will be sent annually.]

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

# Other information you will get from us

You will also get a <plan name> Member ID Card, a New Member Letter with important information, [*insert if applicable:* information about how to access] a *Provider and Pharmacy Directory*, [and] [*insert if applicable*: information about how to access] a *List of Covered Drugs* [*plans that limit DME brands and manufacturers insert*: and a List of Durable Medical Equipment]. Members enrolled in a home and community-based waiver will also get a supplement to their *Member Handbook* that gives information specific to waiver services. If you do not get these items, please call Member Services for assistance.

## J1. Your <plan name> Member ID Card

Under the MyCare Ohio program, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions covered by the plan. 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, this is the only card you need to get services. You will no longer get a monthly Medicaid card. You also do not need to use your red, white, and blue Medicare card. Keep your Medicare card in a safe place, in case you need it 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.

## J2. New Member Letter

Please make sure to read the New Member Letter sent with your *Member Handbook* as it is a quick reference for some important information. For example, it has information on things such as when you may be able to get services from providers not in our network, previously approved services, transportation services, and who is eligible for MyCare Ohio enrollment.

## J3. *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 and pharmacies to get covered services. There are some exceptions, including when you first join our plan (see page <page number>) and for certain services (see Chapter 3 [*plans may insert reference as applicable*]).

[*Plans may modify this language if the Provider and Pharmacy Directory will be sent annually.*] You can ask for a printed *Provider and Pharmacy Directory* at any time by calling Member Services at <toll-free phone and TTY numbers>, <days and hours of operation>. You can also see the *Provider and Pharmacy Directory* at <web address>, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

**Definition of network providers**

* <Plan name>’snetwork 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 Medicaid.

For a full list of network providers, see the *Provider and Pharmacy Directory*.

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

Network providers should not bill you directly for services covered by the plan. For information about bills from network providers, see Chapter 7 <page number>.

**Definition of network pharmacies**

* Network pharmacies are the 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 in an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy.

## J4. *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 [*insert if applicable*: information about how to access] the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, you can visit the plan’s website at <plan website> or call Member Services <phone number>.

[*Plans that do not limit DME brands and manufacturers may delete this section.*]

## J5. 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 <website address>. See Chapter 4, [plans may insert reference, as applicable] to learn more about DME. [*For more information about this requirement, plans may refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.*]

If you are new to <plan name> and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. If you disagree with your doctor, you can ask him or her to refer you for a second opinion.

## J6. *Member Handbook* Supplement or “Waiver Handbook”

This supplement provides additional information for members enrolled in a home and community-based waiver. For example, it includes information on member rights and responsibilities, service plan development, care management, waiver service coordination, and reporting incidents.

## J7. 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 EOB tells you the total amount we, or others on your behalf, have paid for each of your Part D prescription drugs during the month [*insert as appropriate*: and any copays you have made]. The EOB has more information about the drugs you take [*insert, as applicable:* such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options]. Chapter 6 [*plans may insert reference, as applicable*] gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOBis also available when you ask for one. To get a copy, contact Member Services.

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

# How to 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. [*Plans may also insert a reference to Section J in Chapter 8 and/or concise instructions about how members can update their information with the County Department of Job and Family Services.*]

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 are covered and any drug copay amounts for you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

* Changes to your name, your address, or your phone number
* Changes in any other health insurance coverage, such as from your employer, your spouse’s employer, or workers’ compensation
* Admission to a nursing home or hospital
* Care in an out-of-area or out-of-network hospital or emergency room
* Changes in who your caregiver (or anyone responsible for you) is
* You are part or become part of a clinical research study
* If you have to see a provider for an injury or illness that may have been caused by another person or business. For example, if you are hurt in a car wreck, by a dog bite, or if you slip and fall in a store, then another person or business may have to pay for your medical expenses. When you call we will need to know the name of the person or business at fault as well as any insurance companies or attorneys that are involved.

If any information changes, please let us know by calling Member Services at <toll-free phone number(s)>, <days and hours of operation>.

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

## K1. Privacy of your personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, see Chapter 8 [*plans may insert reference, as applicable*].