<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 must revise references to “Medicaid” to use Texas Medicaid 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 long-term services and supports and/or home and community-based services as applicable.]
* [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 phone and TTY numbers, 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 should ensure the Member Handbook is written at or below a 6th grade reading level in English and in Spanish or in the languages of other Major Population Groups if directed by Texas or CMS. The handbook must also be written using the style and preferred terms of the Consumer Information Tool Kit, which can be found at [*hhs.texas.gov/services/health/medicaid-chip/provider-information/texas-medicaid-chip-communications-resources*](https://hhs.texas.gov/services/health/medicaid-chip/provider-information/texas-medicaid-chip-communications-resources).]
* [*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.*
* *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 the <plan name> Medicare-Medicaid Plan**

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

[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 long-term services and supports (LTSS). LTSS 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 name> 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>.

ATTENTION: 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 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 [insert Member Services toll-free phone and TTY numbers, and days and hours of operation]. The call is free. [Plans must provide the information in alternate formats when a Member requests it or when the plan identifies a Member who needs it.]

[*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 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](https://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 Texas Medicaid services, and your membership in it. It also tells you what to expect 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> 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 (LTSS), and other providers. It also has Service Coordinators and service coordination 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 Texas and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the Texas Dual Eligibles Integrated Care Demonstration Project.

The Texas Dual Eligibles Integrated Care Demonstration Project is a demonstration program jointly run by Texas and the federal government to provide better health care for people who have both Medicare and Texas Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Texas Medicaid health care services.

[Plan can include language about itself.]

# Information about Medicare and Medicaid

## 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. Texas Medicaid

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

Each state has its own Medicaid program and 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.

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

* you are eligible to participate in the Texas Dual Eligibles Integrated Care Demonstration Project;
* we offer the plan in your county, and
* Medicare and the State of Texas approve the plan.

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

# Advantages of this plan

You will now get all your covered Medicare and Texas 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 Texas 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 service coordination team that you helped put together. Your service coordination 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 Service Coordinator. 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.
* You will be able to direct your own care with help from your service coordination team and Service Coordinator.
* The service coordination team and Service Coordinator will work with you to come up with a Plan of Care specifically designed to meet your health needs. The service coordination team will be in charge of coordinating the services you need. This means, for example:
* Your service coordination team will make sure your doctors know about all medicines you take so they can reduce any side effects.
* Your service coordination team will make sure your test results are shared with all your doctors and other providers.

# <Plan name>’s 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 <State>: <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.]

Only people who live in one of these counties in our service area can get <plan name>.

**If you move outside of our service area**, you cannot stay in this plan. 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 our plan as long as:

* you are age 21 or older, **and**
* you live in our service area, **and**
* you have both Medicare Part A and Medicare Part B, **and**
* you are a United States citizen or are lawfully present in the United States, **and**
* you are eligible for Texas Medicaid and **at least one** of the following:

have a physical disability or a mental disability and qualify for Supplemental Security Income (SSI), or

* qualify for Texas Medicaid because you receive Home and Community-Based Services (HCBS) waiver services; **and**
* you are NOT enrolled in one of the following 1915(c) waiver programs:
  + Community Living Assistance and Support Services (CLASS)
  + Deaf Blind with Multiple Disabilities Program (DBMD)
  + Home and Community-based Services (HCS)
  + Texas Home Living Program (TxHmL)

# What to expect when you first join a health plan

When you first join the plan, you will get a health risk assessment within the first 90 days.

[Plans should discuss the process for the HRA – 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 90 days or until the new health risk assessment is finished.

After [plans should describe continuity of care requirements: 90 days for most services, but six months for long-term services and supports (LTSS)], you will need to see doctors and other providers in the <plan name> network. Anetwork provideris a provider who works with the health plan.See Chapter 3 [plans may insert reference, as applicable] for more information on getting care.

# Your Plan of Care

Your Plan of Care is the plan for what health services you will get and how you will get them.

After your health risk assessment, your service coordination team will meet with you to talk about what health services you need and want. Together, you and your service coordination team will make your Plan of Care.

Every year, your service coordination team will work with you to update your Plan of Care if the health services you need and want change.

[Plans should add information on Plan of Care and Individual Service Plan for qualifying members.]

# <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 [plans may insert reference, as applicable], or call 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 the months you are enrolled in <plan name> between <start date> and <end date>.

# Other information you will 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 [insert if applicable: information about how to access] a *List of Covered Drugs*.

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

Under our plan, you will have one card for your Medicare and Texas Medicaid services, including long-term services and supports (LTSS) 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 at <toll-free number> 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 Texas Benefits 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. The only exceptions are:

* If you need hospice care, then you will use your Original Medicare card, or
* If you need non-emergency transportation services, then you will use your Texas Benefits Medicaid Card.

## J2. *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 a *Provider and Pharmacy Directory* by calling Member Services at <phone 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.]

### Definition of network providers

* [Plans should modify this paragraph to include all services covered by the state, including long-term supports and services.] 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 (DME) suppliers, and others who provide goods and services that you get through Medicare or Texas Medicaid.

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.

### Definition of 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 mustfill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at <phone number> 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 <website address>. See Chapter 4, [plans may insert reference, as applicable] to learn more about DME.]

## J3. *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, visit <web address> or call <phone number>.

## J4. 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).

TheEOB 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. 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.

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:

* 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
* Any liability claims, such as claims from an automobile accident
* 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 of or become a part of a clinical research study

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

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

## K1. Privacy of 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].