<Plan name> *Member Handbook*

* [*Before use, 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 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 “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 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, "refer to 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 the <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 long-term services and supports. Long-term services and supports provide the care you need at home and/or in the community and may reduce your chances of going to a nursing facility 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.**

<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>.

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, formats that work with screen reader technology, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.

[*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 MassHealth 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 One Care: MassHealth plus Medicare plan. A One Care plan is made up of doctors, hospitals, pharmacies, providers of Long-term Services and Supports (LTSS), 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 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.]

# Information about Medicare and MassHealth

## B1. Medicare

Medicare is the federal health insurance program for:

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

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

## B2. 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 program. That means that each state decides:

* what counts as income and resources,
* who qualifies for Medicaid in that state,
* 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 MassHealth services through our plan as long as:

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

Medicare and Massachusetts approve the plan.

Even if our plan stops operating, this will not affect your eligibility for Medicare and MassHealth services.

# Advantages of the 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 be able to work with **one** health plan for **all** of your health insurance needs.
* 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 an Individualized Care Plan (ICP). 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.
* You can also choose to have 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 and/or other community-based or behavioral health 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 an Individualized Care Plan (ICP) 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 get 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.

# <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 an approved partial county, use county name plus approved ZIP code(s), for example: Our service area includes parts of <county> County with the following ZIP code(s): <ZIP code(s)>.

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.]

<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. Refer to 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:

* 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 going to your doctors and getting your current services for 90 days or until your comprehensive assessment and Individualized Care Plan (ICP) are complete. This is called the Continuity of Care period. 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 comprehensive assessment. After the assessment, you and your Care Team will work together to develop your ICP.

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

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

# Your Individualized Care Plan (ICP)

After your comprehensive 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 your Individualized Care Plan (ICP).

Your ICPlists the services you will get and how you will get them. It includes the services that you need for your physical and behavioral health care and long-term services and supports. The providers you use and medications you take will be a part of your ICP. 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 ICP.

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

# <Plan name> 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.

# 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, refer to 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 refer to 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] the *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] the *List of Covered Drugs*.

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

Under our plan, you will have just one card for your Medicare and MassHealth services, including LTSS 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. Refer to Chapter 7 [plans may insert reference, as applicable] to find out what to do if you get a bill from a provider.

## 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.

You can ask for a *Provider and Pharmacy Directory* at any time by calling Member Services at <toll-free number>. You can also refer to 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.] <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 (DME) 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.

### 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.

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 DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at <website address>. Refer to 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* 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. Refer to 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. To get the most up-to-date information about which drugs are covered, visit <web address> or call <toll-free number>.

## J4. The *Explanation of Benefits*

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

The EOB 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 EOB is also available when you ask for one. To get a copy, contact Member Services.

# 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 they cost**. 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:

* Changes to your name, address, or phone number
* You get other health insurance coverage, like coverage from your employer, your spouse’s employer or your domestic partner’s employer, or workers’ compensation
* Any liability claims, such as claims from an automobile accident
* Admission to a nursing facility or hospital
* Care in an out-of-area or out-of-network hospital or emergency room
* Change in who your caregiver (or anyone else responsible for you) is

You are part of or become 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.]

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

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