<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.*]
* [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.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a TTY number and days and hours of operation.]
* [*Except in disclaimers, plans should reference Member Services’ contact information at the bottom of the page instead of repeating phone numbers and days and hours of operation throughout materials.*]
* [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 you with the help you need, whether you get services at home or in a nursing home. 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, days and hours of operation]. The call is free. [This disclaimer must be included in Spanish and all 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.

[*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 Healthy Connections 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 in the Healthy Connections Prime program. 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 coordinators/care managers (plan’s preference)] 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 South Carolina and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Healthy Connections Prime.

Healthy Connections Prime is a demonstration program jointly run by South Carolina 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

## 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. In South Carolina, Medicaid is called Healthy Connections Medicaid.

Each state decides:

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

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

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

* we choose to offer the plan, **and**
* Medicare and the State of South Carolina approve the plan.

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

# Advantages of this plan

You will now get all your covered Medicare and Healthy Connections 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 Healthy Connections 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 coordinator/care manager (plan’s preference)]. 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 care team and [care coordinator/care manager (plan’s preference)].
* The care team and [care coordinator/care manager (plan’s preference)] will work with you to come up with a care plan specifically designed to meet your health 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

[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.]

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. 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**
* are age 65 or older at the time of enrollment; **and**
* have Medicare Parts A, B, and D; **and**
* are eligible for full Healthy Connections Medicaid benefits; **and**
* are a United States citizen or are lawfully present in the United States.

Even if you meet the above criteria, you are not eligible for our plan if you:

* are part of the Healthy Connections Medicaid spend-down population; **or**
* have Comprehensive Third Party Insurance; **or**
* live in an Intermediate Care Facility for people with Intellectual Disabilities (ICF/IID) or Nursing Facility at the time of eligibility determination; **or**
* are in a hospice program or are getting End-Stage Renal Disease (ESRD) services at the time of eligibility determination; **or**
* are participating in a community long-term care waiver program other than the Community Choices Waiver, HIV/AIDS Waiver, or Mechanical Ventilation Waiver.

You may choose to **either** **enroll** **or** **remain in <plan name>** if you:

* are currently enrolled in a Medicare Advantage plan or in Program of All-inclusive Care for the Elderly (PACE). Enrolling in Healthy Connections Prime will automatically disenroll you from your existing program and any Medicare Part D plan; **or**
* transition from a Nursing Facility or ICF/IID into the community; **or**
* are already enrolled in this plan but later enter a Nursing Facility**; or**
* are enrolled in this plan but enter a hospice program or become eligible for ESRD services.

# What to expect when you first join a health plan

When you first join the plan, you will get an initial health screen within the first 30 days to collect information about your medical and social history and needs.

You will also get a comprehensive assessment within the first 60 or 90 days depending on your health needs. The comprehensive assessment will take a deeper look at your medical needs, social needs, and capabilities. We will get information from you, your providers, and family/caregivers when appropriate. This assessment will be done by qualified and trained health professionals, such as nurses, social workers, and [care coordinators/care managers (plan’s preference)].

We may combine your initial health screen and comprehensive assessment into one assessment that is done within the first 60 days. Generally, people who are enrolled in certain Healthy Connections Medicaid waiver programs [plans may insert other characteristics of high and moderate risk populations] will get the combined initial health screen and comprehensive assessment.

If your comprehensive assessment shows you have very high health needs, you may be required to complete a Long Term Care Assessment with a registered nurse. The Long Term Care Assessment determines whether you need additional care in a nursing facility or through a community-based waiver.

**If <plan name> is new for you**, you can keep using the doctors you go to now and keep your current service authorizations for 180 days after you first enroll. During this time period, you will continue to have access to the same medically necessary items, services, and prescription drugs as you do today. You will also still have access to your medical, mental health and Long Term Services and Supports (LTSS) providers.

Many of your doctors and other providers are in our network already, but if they are not, after 180 days in our plan, you will need to use doctors and other providers in our network. We may help you transition to a network provider in less than 180 days once we have completed your comprehensive assessment, developed a transition plan, and only if you agree. A network provider is a provider whoworkswith the health plan.Refer to Chapter 3 [plans may insert reference, as applicable] for more information on getting care.

# Your care plan

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

After your comprehensive 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.

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

# <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, 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 the number at the bottom of the page. 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] 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 Healthy Connections Medicaid services, including long-term services and supports 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 Healthy Connections 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. 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. There are some exceptions when you first join our plan (refer to page <page number>).

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the number at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* on our website listed at the bottom of the page 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**

* <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, waiver services providers, long-term services and supports providers, and others who provide goods and services that you get through Medicare or Healthy Connections 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 the number at the bottom of the page 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 listed at the bottom of the page. Refer to Chapters 3 and 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. 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, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit our website using the information at the bottom of the page or call Member Services at [*plans should insert as appropriate:* the number at the bottom of the page ***or*** the number at the bottom of the page and <different toll-free number> ***or*** <different 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.

[*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**. Most services are free, but 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 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
* Changes in who your caregiver (or anyone 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 the number at the bottom of the page.

[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, refer to Chapter 8 [plans may insert reference, as applicable].