<Plan name> *Participant 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 (Participant 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 Participants. 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 Participants*.*]
* [*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*https://www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]
* [*Plans may add a front cover to the Participant Handbook that contains information such as the plan name, Participant Handbook title, and contact information for Participant Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for Participants to read other information on the cover. If plans add a front cover, it must contain the Marketing 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.]
* [Plans must change references to “member,” “customer,” “enrollee,” or “beneficiary” to “Participant.”]
* [Where the template instructs inclusion of a phone number, FIDA Plans must ensure it is a toll-free number and include a toll-free TTY/TDD number and *days and hours* of operation.]
* [Plans should refer Participants 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 continues 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 Participant 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>**

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

[Optional: Insert beneficiary name.]  
[Optional: Insert beneficiary address.]

**Participant Handbook Introduction**

This handbook tells you about your coverage under <plan name> (Medicare-Medicaid Plan) from the date you are enrolled with <plan name> through <end date>. It explains how <plan name> covers Medicare and Medicaid services, including prescription drug coverage, at no cost to you. It explains the health care services, behavioral health services, prescription drugs, and long-term services and supports that <plan name> covers. Long-term services and supports include long-term facility-based care and long-term community-based services and supports. Long-term community-based services and supports provide the care you need at home and in your community, and can help 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 *Participant Handbook*.

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

<Plan name> is a Fully Integrated Duals Advantage (FIDA) Plan that is offered by [insert sponsor name]. When this *Participant 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 Participant Services toll-free phone and TTY/TDD numbers and days and hours of operation*]*.* The call is free. [*This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation*.]

You can get this document for free in other formats, such as large print, braille, or audio. Call [*insert Participant Services toll-free phone and TTY/TDD numbers and days and hours of operation*]. The call is free.

[*Plans must simply describe how they will request a Participant’s preferred language and/or format and keep the information as a standing request for future mailings and communications. Plans must also describe how a Participant can change a standing request for preferred language and/or format.*]

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

**Disclaimers**

* [*Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.*]
* Coverage under <plan name> qualifies as minimum essential coverage (MEC). It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement for MEC.
* The State of New York has created a Participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at [icannys.org](http://icannys.org/). (TTY users call 711, then follow the prompts to dial 844-614-8800.)
* [Plans may insert additional disclaimers or state-required statements, including state-required disclaimer language, here.]

Chapter 1: Getting started as a Participant

**Introduction**

This chapter includes information about <plan name>, a health plan that covers all your Medicare and Medicaid services, and your participation 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 *Participant 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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# A. Welcome to <plan name>

<Plan name> is a Fully Integrated Duals Advantage (FIDA) Plan. A FIDA 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 Interdisciplinary Teams (IDTs) to help you manage all your providers and services. They all work together to provide the care you need.

<Plan name> was approved by New York State and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the FIDA Demonstration.

FIDA is a demonstration program jointly run by New York State 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. At present, this demonstration is scheduled to last until December 31, 2018.

[Plan can include language about itself.]

# B. 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 New York 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 New York, Medicaid is called New York Medicaid.

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.

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

* You are eligible to participate in the FIDA Demonstration,
* We choose to offer the FIDA Plan, and
* Medicare and New York State approve <plan name> to participate in the FIDA Demonstration.

If at any time our plan stops operating, your eligibility for Medicare and Medicaid services will not be affected.

# C. Advantages of this FIDA Plan

In the FIDA Demonstration, you will get all your covered Medicare and Medicaid services from <plan name>, including long-term services and supports (LTSS) and prescription drugs. **You do not pay anything to join or get services from this plan.** However, if you have Medicaid with a “spend-down” or “excess income,” you will have to continue to pay your spend-down to the FIDA Plan.

<Plan name> will help make your Medicare and Medicaid benefits work better together and work better for you. Here are some of the advantages of having <plan name>:

* You will be able to work with **one** health plan for **all** of your health insurance needs.
* You will have an Interdisciplinary Team that you help put together.
  + An Interdisciplinary Team (IDT) is a group of people that will get to know your needs and work with you to develop and carry out a Person-Centered Service Plan specific to your needs.
  + Your IDT may include a Care Manager, doctors, service providers, 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.
* You will be able to direct your own care with help from your IDT and your Care Manager.
* The IDT and Care Manager will work with you to come up with a Person-Centered Service Plan specifically designed to meet your needs. The IDT will be in charge of coordinating the services you need. This means, for example:
* Your IDT will make sure your doctors know about all medicines you take so they can reduce any side effects.
* Your IDT will make sure your test results are shared with all your doctors and other providers.
* Your IDT will help you schedule and get to appointments with doctors and other providers.

# D. <Plan name>’s service area

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

Use county name only if approved for entire county, for example: Our service area includes these counties in <State>: <counties>.

For partially approved counties, use county name plus ZIP code, for example: Our service area includes parts of <county> County with the following ZIP codes: <ZIP codes>.

If needed, plans may insert 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 join <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.

# E. What makes you eligible to be a plan Participant

You are eligible for our plan as long as:

* you live in our service area;
* you are entitled to Medicare Part A, enrolled in Medicare Part B, and eligible for Medicare Part D;
* you are eligible for Medicaid;
* you are a United States citizen or are lawfully present in the United States;
* you are age 21 or older at the time of enrollment;
* you require 120 or more days of community-based or facility-based LTSS or are nursing facility clinically eligible and get facility-based long-term support services; **and**

you are not excluded from enrollment based on one of the exclusions listed below.

You will be excluded from joining our plan if:

* you are a resident of a New York State Office of Mental Health (OMH) facility or a psychiatric facility;
* you are getting services from the State Office for People with Developmental Disabilities (OPWDD) system – whether getting services in an OPWDD facility or treatment center, getting services through an OPWDD Waiver, whether you could be getting services in an ICF/IID but you have chosen not to, or otherwise;
* you are expected to be Medicaid eligible for less than six months;
* you are eligible for Medicaid benefits only for tuberculosis related services, breast cancer services, or cervical cancer services;
* you are getting hospice services (at time of enrollment);
* you are eligible for the family planning expansion program;
* you are a resident of an alcohol/substance abuse long-term residential treatment program;
* you are eligible for Emergency Medicaid;
* you are enrolled in the 1915(c) waiver program for Traumatic Brain Injury (TBI);
* you participate in and reside in an Assisted Living Program; **or**
* you are in the Foster Family Care Demonstration.

# F. What to expect when you first join a FIDA Plan

When you first join the plan, you will get a comprehensive assessment of your needs within the first 90 days or within six months of your last assessment if you joined <plan name> from <MLTC plan name>. The assessment will be conducted by a Registered Nurse from <plan name>.

**If <plan name> is new for you**, you can keep seeing the doctors you go to now and getting your current services for a certain amount of time. This is called the “transition period.” In most cases, the transition period will last for 90 days or until your Person-Centered Service Plan is finalized and implemented, whichever is later.

After the transition period, you will need to see doctors and other providers in the <plan name> network. A network provider is a provider who works with <plan name>.See Chapter 3 [plans may insert reference, as applicable] for more information on getting care.

There are two exceptions to the transition period described above:

* If you are a resident of a nursing facility, you can continue to live in that nursing facility for the duration of the FIDA Demonstration, even if the nursing facility does not participate in <plan name>’s network.
* If you are getting services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in <plan name>’s network.

# G. Your Person-Centered Service Plan

Within the first 90 days after your enrollment effective date, you will meet with the members of your Interdisciplinary Team (IDT) to talk about your needs and develop your Person-Centered Service Plan (PCSP). A PCSPis the plan for what health services, long-term services and supports, and prescription drugs you will get and how you will get them.

You will have a comprehensive re-assessment when necessary, but at least every six months. Within 30 days of the comprehensive re-assessment, your IDT will work with you to update your PCSP. At any time, you may ask for a new assessment or an update to your PCSP by calling your Care Manager.

# H. <Plan name> monthly plan premium

There is no monthly plan premium and there are no other costs for participating in <plan name>. However, if you have Medicaid with a “spend-down” or “excess income,” you will have to continue to pay your spend-down to the FIDA Plan.

# I. The *Participant Handbook*

This *Participant 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], call 1-800-MEDICARE (1-800-633-4227), or call the Independent Consumer Advocacy Network at 1-844-614-8800. You may also complain about the quality of the services we provide by calling Participant Services at <phone number>.

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

# J. Other information you will get from us

You should have already gotten a <plan name> Participant 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> Participant ID Card

Under our plan, 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. Here’s a sample card to show you what yours will look like:

[Insert picture of front and back of Participant 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 Participant Services right away and we will send you a new card.

As long as you are a Participant of our plan, you do not need to use your red, white, and blue Medicare card or your 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> Participant 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. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* is a list of the providers and pharmacies in the <plan name> network. While you are a Participant 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>). There are also some exceptions if you cannot find a provider in our plan who can meet your needs. You will need to discuss this with your Interdisciplinary Team (IDT).

You can ask for a *Provider and Pharmacy Directory* by calling Participant Services at <toll-free 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.] <Plan name>’s network providers include:
  + Doctors, nurses, and other health care professionals that you can go to as a Participant 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.

Network providers have agreed to accept payment from our plan for covered services as payment in full. By seeing these providers, you will not have to pay anything for covered services.

**Definition of network pharmacies**

* Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan Participants. 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 pay for them. There are no costs to you when you get prescriptions from network pharmacies.

Call Participant Services at <toll-free phone number> for more information. Both Participant 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 Participant 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 <toll-free 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).

The *Explanation of Benefits* tells you the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* is also available when you ask for one. To get a copy, please contact Participant Services.

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

# K. How to keep your Participant record up to date

[In the heading and this section, plans should substitute the name used for this file if it is different from “Participant record.”]

You can keep your Participant 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 Participant 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
* Admissions 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 Participant Services at <phone number>.

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

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

The information in your Participant 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 personal PHI, see Chapter 8 [plans may insert reference, as applicable].