<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 should follow the instructions in the State-specific Marketing Guidance regarding use of the standardized plan type (Medicare-Medicaid Plan) following the plan name. Plans should not use ICO when referring to themselves. Plans should use health plan or MI Health Link where appropriate.*]
* [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 supports and services and/or home and community-based services as applicable.]
* [Plans may change references of “member” to “enrollee” as they choose.]
* [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 and section. For example, "refer to Chapter 9, Section A." 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.*]

**<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 Michigan Medicaid and Medicare covered benefits, when applicable.]

[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 supports and services. Long term supports and services 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 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>. [Plans can also change this language in this paragraph to make it appropriate for particular plan’s marketing name.]

[Plans may include either the current multi-language insert or provide a Notice of Availability. Plans that choose to use the current multi-language insert per 42 CFR §§ 422.2267(e)(31) and (e)(33) should include:We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at <phone number>. Someone that speaks <language> can help you. This is a free service. [This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state.]

*OR*

*Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31) and 423.2267(e)(33), plans may choose to provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in Michigan and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.*]

[*Plans that meet the 5% alternative language or Medicaid required language threshold insert:* This document is available for free in [*insert languages that meet the threshold as described the “Standards for required materials and content section” of the Marketing Guidance for Michigan Medicare-Medicaid Plans*].]

[*Plans must increase the font size and may use bold font to emphasize the following information.*]You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free..

[*Plans also must describe in simple terms:*

* + *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 Michigan 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 supports and services, and other providers. It also has care coordinators 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 Michigan and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MI Health Link program.

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

[Plan must include the name of the ICO’s parent company and any doing business name that may be used and can include language about itself.]

# Information about Medicare and Michigan Medicaid

## B1. Medicare

Medicare is the federal health insurance program for the following people:

* 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. Michigan Medicaid

Michigan Medicaid is a program run by the federal government and the State of Michigan that helps people with limited incomes and resources pay for long term supports and services and medical costs. It also covers extra services and drugs not covered by Medicare. Each state has its own Medicaid program.

This means that 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 own Medicaid programs, as long as they follow the federal rules.

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

* you are eligible to participate,
* we choose to offer the plan, **and**
* Medicare and the State of Michigan approve the plan.

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

# Advantages of this plan

You will now get all your covered Medicare and Michigan 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 Michigan 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 not pay a deductible or copay when you get services from a provider or pharmacy in our health plan’s provider network.(You will be required to keep paying any monthly Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting [www.michigan.gov/mdhhs/0,5885,7-339-73970\_5461---,00](https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html).)
* You will have your own Care Coordinator who will ask you about your health care needs and choices and work with you to create a personal care plan based on your goals. We call this person-centered planning.
* Your Care Coordinator will help you get what you need, when you need it. This person will answer your questions and make sure that your health care issues get the attention they deserve.
* If you qualify, you will have access to home and community-based supports and services to help you live independently.

[Plans may insert additional advantages as they choose.]

# <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 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 the following are true:

* you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), **and**
* you have Medicare Part A, Part B, and Part D, **and**
* you are eligible for full Michigan Medicaid benefits, **and**
* you are a United States citizen or are lawfully present in the United States, **and**
* you are not already enrolled in hospice, **and**
  + to learn more about the hospice benefit please look at Chapter 4 [plans may insert reference, as applicable] of the Member Handbook
* you are not enrolled in the MI Choice waiver program or the Program of All-inclusive Care for the Elderly (PACE). If you are enrolled in either of these programs, you need to disenroll before enrolling in the MI Health Link program through <plan name>.

# What to expect when you first join a health plan

You will get a Level I Assessment within the first 60 days of joining our plan. [Plans should discuss the process for the Level I Assessment – who performs it, who will contact the member, etc.]

**If <plan name> is new for you**, you can keep getting services and using the doctors and other providers you use now for at least 90 days from your enrollment start date.

The Habilitation Supports Waiver or Specialty Services and Supports Program services provided by the Prepaid Inpatient Health Plan (PIHP) that you may currently be receiving will not change due to your enrollment in <plan name>. For all other services, you will be able to continue seeing the doctors and providers you use now for up to 180 days from your enrollment start date.

After [plans should describe continuity of care requirements], 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.

# Your care plan

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

After your Level I 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 a 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 <toll-free phone and TTY numbers>. You can also refer to the *Member Handbook* at <MMP URL> 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 important information will you 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 andmanufacturers 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 Michigan Medicaid services, including long term supports and services 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 Michigan 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 section <section letter>).

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at <toll-free phone and TTY numbers>, <days and hours of operation>. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at <MMP URL> 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, nurse practitioners, psychologists, hearing, dental, or vision specialists, nurses, pharmacists, therapists, and other health care professionals that you can use as a member of our plan;
  + clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  + home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Michigan Medicaid.

Network providers have agreed to accept payment from our plan 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 must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Member Services at <toll-free phone and TTY numbers>, <days and hours of operation> 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 <MMP URL>. 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*. 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 <MMP URL> or call <toll-free phone and TTY numbers>.

## 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. 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 your domestic partner’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 part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

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

[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].