<Plan name>

Member Handbook

[Plans must revise references to “Medicaid” to use Michigan Medicaid, the state-specific name for the program throughout the handbook.

[Where the template uses “medical care,” “medical services,” or “health care services,” to explain services provided, plans may revise and/or add references to long term 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 should include a TTY/TDD number and hours of service.]

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

**<start date> – <end date>**

## Your Health and Drug Coverage under the <plan name>

[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.]

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. **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.]*

You can speak with someone about getting this information in other languages. Call <toll-free number>. The call is free. [*The preceding sentence must be in English, Arabic and Spanish. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]

You can ask for this handbook in other formats, such as Braille or large print. Call [insert Member Service phone and TTY/TDD numbers, and hours of operation].

## Disclaimers

[Insert plan’s legal or marketing name] is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

Limitations, restrictions, and patient pay amounts may apply. This means that you may have to pay for some services and that you need to follow certain rules to have <plan name> pay for your services. For more information, call <plan name> <Member Services> or read the <plan name> Member Handbook.

Benefits, List of Covered Drugs*,* and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year. Please contact the plan for more details.

[Plans may insert additional disclaimers or state-required statements, including state-required disclaimer language, here.]

Chapter 1: Getting started as a member

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# Welcome to <plan name>

<Plan name> is a Medicare-Medicaid Plan. A *Medicare-Medicaid Plan,* also known as an *Integrated Care Organization* (or *ICO*)*,* 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 receive your Medicare and Michigan Medicaid health care services.

[Plan can include language about itself.]

# What are Medicare and Michigan Medicaid?

## 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).

## 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 and who qualifies for Medicaid. They also decide what services are covered by Medicaid and the cost for those 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 would not be affected.

# What are the 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 not pay a deductible or copayment when you get services from a provider or pharmacy in our health plan’s provider network.
* You will have your own Care Coordinator who will ask you about your health care needs and choices and will work with you to create a personal care plan based on your goals.
* 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*.]

# What is <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 more than one row to describe their service area.]

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.

# 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***
* you have Medicare Part A, Part B, and Part D, ***and***
* you are eligible for full Michigan Medicaid benefits, ***and***

you are not enrolled in hospice, **and**

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 our plan

“You will receive a Level I Assessment within the first 45 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 receiving services and seeing the doctors and other providers you go to now for at least 90 days from your enrollment start date. If you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP, you will be able to receive services and see the doctors and providers you go to now for up to 180 days from your enrollment start date. Your care coordinator will work with you to choose new providers and arrange services within this time period if your current provider is not part of <plan name>’s provider network. Call <plan name> for information about nursing home services.

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

# What is a care plan?

A *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, and when the health services you need and want change, your care team will work with you to update your care plan.

# Does <plan name> have a monthly plan premium?

No.

# About the Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all   
of the rules in this document. If you think we have done something that goes against   
these rules, you may be able to appeal, or challenge, our action. For information about   
how to appeal, see Chapter 9 [plans may insert reference, as applicable], or call   
1-800-MEDICARE (1-800-633-4227).

The contract is in effect for the months you are enrolled in <plan name> between <start date> and <end date>.

# What other 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*, and a *List of Covered Drugs*.

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.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the <plan name> network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page <page number>).

* You can request an annual *Provider and Pharmacy Directory* by calling Member Services at <phone number>. [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, on the plan’s website, or from Member Services. For example: You can also see the Provider and Pharmacy Directory at <web address>, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.]

### What are “network providers”?

* [Plans should modify this paragraph to include all services covered by the state, including long term supports and services.] Network providers are doctors, nurses, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They also include home health agencies, 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.

### What are “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 <phone number> for more information or to get a copy of the *Provider and Pharmacy Directory.* You can also see the *Provider and Pharmacy Directory* at <web address>, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

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 a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit <web address> or call <phone number>.

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 you 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. 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* summary is also available upon request. To get a copy, please contact Member Services.

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

# How can you 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:

* If you have any changes to your name, your address, or your phone number
* If you have any changes in any other health insurance coverage, such as from your employer, your spouse’s employer, or workers’ compensation
* If you have any liability claims, such as claims from an automobile accident
* If you are admitted to a nursing home or hospital
* If you get care in an out-of-area or out-of-network hospital or emergency room
* If your caregiver or anyone responsible for you changes

If you are part of a clinical research study

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

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

## Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see [plans may insert reference, as applicable].