<Plan name> *Member Handbook*

* [*Before use, plans must upload in HPMS only (1) a standalone ANOC and (2) a standalone EOC (Member Handbook). Plans should work with their marketing reviewers to withdraw any duplicate material submitted in error. Plans must enter Actual Mail Dates (AMDs) for ANOCs in accordance with CMS requirements* as detailed in the “Update AMD/Beneficiary Link/Function” section of the Marketing Review Users Guide in HPMS. Note that plans must enter AMD information for ANOC mailings only for mailings to current members. Plans should not enter ANOC AMD information for October 1, November 1, or December 1 effective enrollment dates or for January 1 effective enrollment dates for any new members*.*]
* [*Plans may add a front cover to the Member Handbook that contains information such as the plan name, Member Handbook title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID.*]
* [Plans must revise references of “Medicaid” to use the state-specific name for the program (Medi-Cal) throughout the handbook.]
* [Plans should change “MMP” to Cal MediConnect Plan. Plans must use the “(Medicare-Medicaid Plan)” standardized plan type label following the plan name at least once on the front page or beginning of each marketing piece.]
* [Plans must include “Cal MediConnect Plan” in the plan marketing name.]
* [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. Cal MediConnect is about the coordination of medical, social and behavioral services.]
* [Plans may change references to “member,” “customer,” or “beneficiary” to whatever term they prefer.]
* [If plans do not use the term “medical group,” plans should replace it with the term the plan uses.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]
* [*Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
* *Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert:* **This section is continued on the next page***).*
* *Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.*
* *Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.*
* *Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long-term services and supports (LTSS) or low income subsidy (LIS)).*
* *Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.*
* *Avoid separating a heading or subheading from the text that follows when paginating the model.*
* *Use universal symbols or commonly understood pictorials.*
* *Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.*
* *Consider using regionally appropriate terms or common dialects in translated models.*
* *Include instructions and navigational aids in translated models in the translated language rather than in English.*
* *Consider producing translated models in large print.*]

**<start date> – <end date>**

**Your Health and Drug Coverage under <plan name>**

[Plans: Revise this language to reflect that the organization is providing both Medi-Cal 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 (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Long-term services and supports 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 Cal MediConnect Plan is offered by [insert sponsor name]. When this *Member Handbook* says “we,” “us,” or “our,” it means [insert sponsor name]. When it says “the plan” or “our plan,” it means <plan name>.

ATTENTION: If you speak [insert language of the disclaimer], language assistance services, free of charge, are available to you. Call [insert Member Services toll-free phone and TTY numbers, and days and hours of operation]. The call is free. [This disclaimer must be included in 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, and/or audio. Call [insert Member Services toll-free phone and TTY numbers, and 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 Medi-Cal 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.]

Table of Contents

[A. Welcome to <plan name> 7](#_Toc73042583)

[B. Information about Medicare and Medi-Cal 7](#_Toc73042584)

[B1. Medicare 7](#_Toc73042585)

[B2. Medi-Cal 7](#_Toc73042586)

[C. Advantages of this plan 8](#_Toc73042587)

[D. <Plan name>’s service area 8](#_Toc73042588)

[E. What makes you eligible to be a plan member 9](#_Toc73042589)

[F. What to expect when you first join a health plan 9](#_Toc73042590)

[G. Your Care Team and Care Plan 10](#_Toc73042591)

[G1. Care Team 10](#_Toc73042592)

[G2. Care Plan 11](#_Toc73042593)

[H. <Plan name> monthly plan premium 11](#_Toc73042594)

[I. The *Member Handbook* 11](#_Toc73042595)

[J. Other information you will get from us 11](#_Toc73042596)

[J1. Your <plan name> Member ID Card 12](#_Toc73042597)

[J2. *Provider and Pharmacy Directory* 12](#_Toc73042598)

[J3. *List of Covered Drugs* 13](#_Toc73042599)

[J4. The *Explanation of Benefits* 13](#_Toc73042600)

[K. How to keep your membership record up to date 14](#_Toc73042601)

[K1. Privacy of personal health information (PHI) 14](#_Toc73042602)

# Welcome to <plan name>

<Plan name> is a Cal MediConnect Plan. A Cal MediConnect Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, 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 California and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Cal MediConnect.

Cal MediConnect is a demonstration program jointly monitored by California and the federal government to provide better care for people who have both Medicare and Medi-Cal. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medi-Cal services.

[Plan can include language about itself.]

# Information about Medicare and Medi-Cal

## 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. Medi-Cal

Medi-Cal is the name of California’s Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

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 Medi-Cal approves their plan each year, if applicable.] Medicare and California approved <plan name>. You can get Medicare and Medi-Cal services through our plan as long as:

* We choose to offer the plan, **and**
* Medicare and the State of California allow us to continue to offer this plan.

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

# Advantages of this plan

You will now get all your covered Medicare and Medi-Cal services from <plan name>, including prescription drugs. **You will not pay extra to join this health plan.**

<Plan name> will help make your Medicare and Medi-Cal 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 help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
* You will have access to a care coordinator. This is a person who works with you, with <plan name>, and with your care team to help make a care plan.
* You will be able to direct your own care with help from your care team and care coordinator.
* The care team and care coordinator will work with you to come up with a care plan specifically designed to meet your health needs. The care team will help coordinate the services you need. This means, for example:
* Your care team will make sure your doctors know about all the medicines you take so they can make sure you are taking the right medicines, and so your doctors can reduce any side effects you may have from the medicines.
* Your care team will make sure your test results are shared with all your doctors and other providers, as appropriate.

# <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) that are excluded from Cal MediConnect, for example: Our service area includes all parts of <county> with the exception of 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 join <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. You will need to contact your local county eligibility worker:

[Insert contact information for the local Medi-Cal office.]

# 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 21 and older at the time of enrollment, **and**
* Have both Medicare Part A and Medicare Part B, **and**
* Are currently eligible for Medi-Cal and [insert language as appropriate under terms of state contract], **and**
* Are a United States citizen or are lawfully present in the United States.

There may be additional eligibility rules in your county. Call Member Services for more information.

# What to expect when you first join a health plan

When you first join the plan, you will get a health risk assessment (HRA) within the first [plans should define when the HRA must be completed per the three-way contract (e.g., within 90 days)].

We are required to complete an HRA for you. This HRA is the basis for developing your individual care plan (ICP). The HRA will include questions to identify your medical, LTSS, and behavioral health and functional needs.

We will reach out to you to complete the HRA. The HRA can be completed by an in-person visit, telephone call, or mail.

We will send you more information regarding this HRA.

**If <plan name> is new for you**, you can keep using the doctors you use now for a certain amount of time. You can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:

* You, your representative, or your provider makes a direct request to us to continue to use your current provider.
* We can establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say existing relationship, it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in <plan name>.
  + We will determine an existing relationship by reviewing your health information available to us or information you give us.
  + We have 30 days to respond to your request. You may also ask us to make a faster decision and we must respond in 15 days.
  + We have 3 calendar days to respond to your request if there is a risk you will be harmed due to an interruption in your care.
  + You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

**Note:** This request **cannot** be made for providers of Durable Medical Equipment (DME), transportation, other ancillary services, or services not included under Cal MediConnect.

After the continuity of care period ends, you will need to use doctors and other providers in the <plan name> network [insert if applicable: that are affiliated with your primary care provider’s medical group], unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan.[Plans that assign members to medical groups/IPAs must include an explanation of the term(s) here.] Refer to Chapter 3 [plans may insert reference, as applicable] for more information on getting care.

# Your Care Team and Care Plan

## G1. Care Team

Do you need help getting the care you need? A care team can help you. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person who is trained to help you manage the care you need. You will get a care coordinator when you enroll in <plan name>. This person will also refer you to community resources, if <plan name> does not provide the services that you need.

You can call us at <phone number> to ask for a care team.

## G2. Care Plan

Your care team will work with you to come up with a care plan. A care plan tells you and your doctors what services you need, and how you will get them. It includes your medical, behavioral health, and LTSS needs. Your care plan will be made just for you and your needs.

Your care plan will include:

* Your health care goals.
* A timeline for when you should get the services you need.

After your health risk assessment, your care team will meet with you. They will talk to you about services you need. They can also tell you about services you may want to think about getting. Your care plan will be based on your needs. Your care team will work with you to update your care plan at least every year.

# <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 <phone number>. You can also refer to the *Member Handbook* at <web address> or download it from this website. [Plans may modify language if the Member Handbook will be sent annually.]

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

# Other information you will get from us

You should have already gotten a <plan name> Member ID Card, [insert if applicable: information about how to access] 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 Medi-Cal services, including long-term services and supports, certain behavioral health services, and prescriptions. You must show this card when you get any services or prescriptions. Here is a sample card to show you what yours will look like:

[Insert picture of front and back of Member ID Card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).]

If your Cal MediConnect card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. You can call Member Services at <phone number>.

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 Medi-Cal card to get Cal MediConnect 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.

Please remember, for the specialty mental health services that you may get from the county mental health plan (MHP), you will need your Medi-Cal card to access those services.

## 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 <phone numbers>. You can also refer to the *Provider and Pharmacy Directory* at <web address> or download it from this website. [Plans may modify language if the Provider and Pharmacy Directory will be sent annually.]

[Plans must add information describing the information available in the directory.]

**Definition of network providers**

* <Plan name>’s network providers include:
  + Doctors, nurses, 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**
  + LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

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 help you pay for them.

Call Member Services at <phone number> 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 <website address>. Refer to Chapter 4 [plans may insert reference, as applicable] to learn more about DME equipment.]

## J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells you 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 <web address> or call <phone 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* (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 at <phone number>.

[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 a 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 <phone number>.

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

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

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