

<Plan name> *Member Handbook*

- ❖ *[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 use Medi-Cal for Medi-Cal in references to “Medi-Cal” in any plan-customized language throughout the Member Handbook.]*
- ❖ *[Plans may modify the language in the Member Handbook, as applicable, to address Medi-Cal benefits and cost-sharing for its dual eligible population.]*
- ❖ *[Throughout the document plans should update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medi-Cal plans, etc.)]*
- ❖ *[Where the Member Handbook 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 may change references to terms such as “member,” “customer,” “beneficiary,” “member services,” “health risk assessment,” “care coordinator,” “primary care provider,” “prior authorization (PA),” “prior approval,” “nursing facility,” and “urgently needed care,” etc. as instructed by the state or based on plan preference and update them consistently throughout the Member Handbook.]*
- ❖ *[Where the model material instructs inclusion of a plan phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]*
- ❖ *[Throughout the Member Handbook, in addition to following all Medicare and Medi-Cal requirements in regulation and the Medicare Communications and Marketing Guidelines, plans must follow additional applicable style rules of the state, if any.]*
- ❖ *[Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, “refer to Chapter 9, Section A, page 1.” An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]*



- ❖ *[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 by the state.*
 - *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)). Plans may choose to spell out terms each time they are used.*
 - *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 <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 *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan 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. Key terms and their definitions appear in alphabetical order in **Chapter 12** of your *Member Handbook*.

This is an important legal document. Keep it in a safe place.

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means *[insert plan name]*.

[Plans that meet the 5% alternative language or Medi-Cal required language threshold insert: This document is available for free in [insert the languages that meet the threshold].]

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

[Plans also simply describe:

- *how they request a member’s preferred language other than English and/or alternate format,*
- *how they 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.]*

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 *[insert phone number]*. Someone that speaks *[insert language]* can help you. This is a free service. *[This information must be included in the*



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

following languages: Arabic, Armenian, Cambodian, Chinese, Farsi, French, French Creole, Hindi, Hmong, Italian, German, Japanese, Korean, Laotian, Mien, Polish, Portuguese, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian, Vietnamese, and any additional languages required by the state.]

[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 federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), the Medicare Communications and Marketing Guidelines, and included in any state-specific 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 *[insert 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 for more information on the individual shared responsibility requirement.



Chapter 1: Getting started as a member

Introduction

This chapter includes information about *[insert plan name]*, a health plan that covers all of your Medicare services and coordinates all of 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 us. Key terms and their definitions appear in alphabetical order in the last chapter of your *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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If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

A. Welcome to our plan

Our plan provides Medicare and Medi-Cal services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

[Plan can include language about itself.]

B. Information about Medicare and Medi-Cal

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- 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 Medi-Cal 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 is eligible,
- 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.

Medicare and the state of California approved our plan. 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.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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

C. Advantages of our plan

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

We help make your Medicare and Medi-Cal benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You 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 have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
 - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
 - Your test results are shared with all of your doctors and other providers, as appropriate.

New members to <plan name>: In most instances you will be enrolled in <plan name> for your Medicare benefits the 1st day of the month after you request to be enrolled in <plan name>. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through <plan name>. There will be no gap in your Medi-Cal coverage. Please call us at <phone and TTY/TDD numbers> if you have any questions.

D. Our plan's service area

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



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

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 ZIP code(s) that are excluded, 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 our plan.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- are age 21 and older at the time of enrollment, **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for Medi-Cal, **and**

If you lose Medi-Cal eligibility but can be expected to regain it within *[Insert the time period for deemed continued eligibility in days or months, not less than three months. Plans may choose any length of time from three to six months for deeming continued eligibility, as long as they apply the criteria consistently across all members and fully inform members of the policy. States may specify the required length of deemed continued eligibility in the State Medi-Cal Agency Contract.]* then you are still eligible for our plan. (Chapter 4, Section A tells you about coverage and cost sharing during this period, which is called deemed continued eligibility).

Call Member Services for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

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

We'll send you more information about this HRA.

If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, if they are not in our network. We call this continuity of care. If they are not in our network, 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 asks us to let you keep using your current provider.
- We 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 our plan.
 - We determine an existing relationship by reviewing your available health information available or information you give us.
 - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. If you are at risk of harm, we must respond within 3 days.
 - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: You can make this request for providers of Durable Medical Equipment (DME) for at least 90 days until we authorize a new rental and have a network provider deliver the rental. Although you cannot make this request for providers of transportation or other ancillary providers, you can make a request for services of transportation or other ancillary services not included in our plan.

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** of your *Member Handbook* for more information on getting care.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 10

G. Your care team and care plan

G1. Care team

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

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS or other services.

Your care plan includes: *[Update the description of the care plan and the process as outlined in your model of care (MOC)].*

- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Your monthly costs for *[insert plan name]*

[Plans should revise this section to only include premium types that apply, delete the portions of Section H that are not applicable, and renumber any remaining portions of Section H as appropriate. If plan has no monthly premium revise section with “Our plan has no premium”.]

Your costs may include the following:

- Plan premium (Section H1)
- Monthly Medicare Part B Premium (Section H2)
- Optional Supplemental Benefit Premium (Section H3)

In some situations, your plan premium could be less.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 11

H1. Plan premium

[If applicable, plans should revise this section to indicate that the plan premium is paid on behalf of members (e.g. by “Extra Help,” Medi-Cal).]

As a member of your plan, you pay a monthly plan premium. *[Select one of the following: For 2024, the monthly premium for [insert 2024 plan name] is [insert monthly premium amount]]. OR The monthly premium amount for [insert 2024 plan name] is listed in [describe attachment.] [Plans may insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC.]*

[Plans with no premium should delete this section.]

H2. Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

[Plans that include a Medicare Part B premium reduction benefit may describe the benefit within this section.]

[Plans that do not have any members paying Medicare premiums or plans whose members must pay the full Medicare Part B premium should modify this section.]

[Plans with no monthly premium, omit: In addition to paying the monthly plan premium,] some members are required to pay other Medicare premiums. As explained in Section E above, in order to be eligible for our plan, you must maintain your eligibility for Medi-Cal as well as have both Medicare Part A and Medicare Part B. For most *[insert 2024 plan name]* members, Medi-Cal pays for your Medicare Part A premium (if you don't qualify for it automatically) and for your Medicare Part B premium.

If Medi-Cal is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren't eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

H3. Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called “optional supplemental benefits,” then you pay additional premium each month for these extra benefits. Refer to Chapter 4, Section E for details. *[If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section.]*

I. Your Member Handbook



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 12

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

The contract is in effect for the months you are enrolled in our plan between *[insert start date]* and *[insert end date]*.

J. Other important information you get from us

Other important information we provide to you includes your 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 (DME),]* and *[insert if applicable: information about how to access]* a *List of Covered Drugs*, also known as a *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

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

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. 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 Medi-Cal card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access the following services:

- *[Plans should include bullets describing which services members will need to use their BIC card to receive, including Medi-Cal Dental benefits, county behavioral health services, and In Home Supportive Services.]*



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 13

J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. 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 *[insert web address if different than the one in the footer or insert: at the web address at the bottom of the page]*.

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

Definition of network providers

- Our 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 (DME) suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree 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 *[insert if applicable: help you]* pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our 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 Chapter 4 of the Medicare Managed Care Manual):



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>.

List of Durable Medical Equipment (DME)

We sent you our List of DME with this *Member Handbook*. 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 the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Member Handbook* 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 our plan covers.

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** of your *Member Handbook* for more information.

Each year, we 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, call Member Services or visit our website at the address at the bottom of the page.

J4. The Explanation of Benefits

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare 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, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. 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** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

[Plans may insert other methods for members to get their EOB.]

K. Keeping your membership record up to date

[In the Table of Contents, section heading, and text, plans substitute the name for this file if it differs from “membership record.”]

You can keep your membership record up to date by telling us when your information changes.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <web address>. 15

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

- changes to your name, your address, or your phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and,**
- if you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

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

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.

