<Plan name>

Member Handbook

Where “Healthy Connections” or “Medicaid” is referenced (except where it is used in "Medicare-Medicaid Plan"), the term “Healthy Connections Medicaid” must be used. However, the first instance of “Healthy Connections Medicaid” in the document should include “South Carolina” (i.e., “South Carolina Healthy Connections Medicaid”)]

[Where the template uses “medical care,” “medical services,” or “health care services,” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]

[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> Medicare-Medicaid Plan

[Optional: Insert beneficiary name.]  
[Optional: Insert beneficiary 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 services and supports. Long-term services and supports provide you with the help you need, whether you get services at home or in a nursing home. **This is an important legal document. Please keep it in a safe place.**

This <plan name> 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>*.* <Plan name> provides both South Carolina Healthy Connections Medicaid and Medicare covered benefits.

This information is available for free in other languages. Please call our customer service number at [insert Member Service phone and TTY/TDD numbers, and hours of operation]. The call is free.

[This disclaimer must be placed in English and Spanish. The Spanish 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 South CarolinaHealthy Connections Medicaid to provide benefits of both programs to enrollees.

Limitations[, copays,] and restrictions may apply. For more information, call <plan name> <Member Services> or refer to the <plan name> Member Handbook. 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.

Benefits, List of Covered Drugs*,* [and] pharmacy and provider networks [, and/or co-payments] may change from time to time throughout the year and on January 1 of each year.

[*Plans that charge $0 copays for all Part D drugs may delete this disclaimer.*] Copays for prescription drugs may vary based on the level of Extra Help you receive. 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 in the Healthy Connections Prime program. A *Medicare-Medicaid plan* is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has [care coordinators/care managers (plan’s preference)] 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 and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Healthy Connections Prime.

Healthy Connections Prime is a demonstration program jointly run by South Carolina and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you receive your Medicare and Medicaid health care services.

[Plan can include language about itself.]

# What are Medicare and 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).

## Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. In South Carolina, Medicaid is called Healthy Connections Medicaid.

Each state decides what counts as income and resources and who qualifies. They also decide 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 South Carolina must approve <plan name> each year. You can get Medicare and Healthy Connections Medicaid services through our plan as long as:

* we choose to offer the plan, and

Medicare and the State approve the plan.

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

# What are the advantages of this plan?

You will now get all your covered Medicare and Healthy Connections 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 Healthy Connections Medicaid benefits work better together and work better for you. Some of the advantages include:

* You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
* You will have a [care coordinator/care manager (plan’s preference)]. This is a person who works with you, with <plan name>, and with your care providers to make sure you get the care you need.
* You will be able to direct your own care with help from your care team and [care coordinator/care manager (plan’s preference)].
* The care team and [care coordinator/care manager (plan’s preference)] will work with you to come up with a care plan specifically designed to meet your health needs. The care team will be in charge of coordinating the services you need. This means, for example:
* Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
* Your care team will make sure your test results are shared with all your doctors and other providers.

# 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 are age 65 or older at the time of enrollment; ***and***
* you have Medicare Parts A, B, and D; ***and***
* you are eligible for full Healthy Connections Medicaid benefits*.*

Even if you meet the above criteria, you are not eligible for our plan if:

* You are part of the Healthy Connections Medicaid spend-down population; **or**
* You have Comprehensive Third Party Insurance; **or**
* You live in an Intermediate Care Facility for people with Intellectual Disabilities (ICF/IID) or Nursing Facility at the time of eligibility determination; **or**
* You are in a hospice program or are receiving End-Stage Renal Disease (ESRD) services at the time of eligibility determination; **or**
* You are participating in a community long-term care waiver program other than the Community Choices Waiver, HIV/AIDS Waiver, or Mechanical Ventilation Waiver.

You may choose to enroll or **remain in the plan** if:

* You are enrolled in a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) and you choose to disenroll from your existing program; **or**
* You transition from a Nursing Facility or ICF/IID into the community; **or**
* You are already enrolled in this plan but later enter a Nursing Facility**; or**
* You are enrolled in this plan but enter hospice programs or become eligible for ESRD services.

# What to expect when you first join a health plan

**When you first join the plan**, you will receive an initial health screen within the first 30 days to collect information about your medical and social history and needs.

You will also receive a comprehensive assessment within the first 60 or 90 days depending on your health needs. The comprehensive assessment will take a deeper look at your medical needs, social needs, and capabilities. We will get information from you, your providers, and family/caregivers when appropriate. This assessment will be done by qualified and trained health professionals, such as nurses, social workers, and [care coordinator/care manager (plan’s preference)].

We may combine your initial health screen and comprehensive assessment into one assessment that is done within the first 60 days. Generally, people who are enrolled in certain Healthy Connections Medicaid waiver programs [plans may insert other characteristics of high and moderate risk populations] will receive the combined initial health screen and comprehensive assessment.

If your comprehensive assessment shows you have very high health needs, you may be required to complete a Long Term Care Assessment with a registered nurse. The Long Term Care Assessment determines whether you need additional care in a nursing facility or through a community-based waiver.

**If <plan name> is new for you**, you can keep seeing the doctors you go to now and keep your current service authorizations for 180 days after you first enroll. During this time period, you will continue to have access to the same medically necessary items, services, and prescription drugs as you do today. You will also still have access to your medical, mental health and Long Term Services and Supports (LTSS) providers.

Many of your doctors and other providers are in our network already, but if they are not, after 180 days in our plan, you will need to see doctors and other providers in our network. We may help you transition to a network provider in less than 180 days once we have completed your comprehensive assessment, developed a transition plan, and only if you agree. *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 health services you will get and how you will get them.

After your comprehensive 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 when the health services you need and want change.

# 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 Healthy Connections Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions. Here’s a sample card to show you what yours will look like:

[Insert picture of front and back of 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 Healthy Connections 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”?

* 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, waiver services providers, long-term services and supports providers, and others who provide goods and services that you get through Medicare or Healthy Connections Medicaid.

Network providers have agreed to accept payment from our plan [plans with cost sharing, insert: and cost sharing] 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 help you 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**. Most services are free, but 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 facility 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].