<Plan name> *Member Handbook*

- [*Plans can 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 can add a logo and/or photographs to the front cover as long as these elements don't make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID*.]

- [*States can choose to use the term Evidence of Coverage instead of Member Handbook and modify this term throughout all chapters*.]

- [*Plans must use the state-specific name for Medicaid in references to "Medicaid" in any plan-customized language throughout the Member Handbook*.]

- [*Plans can modify the language in the Member Handbook, as applicable, to address Medicaid 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 Medicaid plans, etc*.)]

- [*Where the Member Handbook uses "medical care", "medical services", or "health care services" to explain services provided, plans can revise and/or add references to long-term services and supports and/or home and community-based services as applicable*.]

- [*Plans can 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's 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 Medicaid 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 and section as appropriate. For example, "refer to Chapter 9, Section A." An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the Member Handbook. Plans can always include additional references to other sections, chapters, and/or member materials when helpful to the reader.*]

OMB Approval 0938-1444 (Expires: TBD)

- [*Plans must include the OMB approval information in the footer of the first page of the document as noted in this model.*]
- [*Plans must include the Material ID: H number description of choice (M or C) at the bottom of the first page of the document*.]
- [*Standardized materials must be used by all D-SNPs exactly as provided, unless otherwise indicated below and/or in the instructions within the EOC.*

  Permissible Alterations/Modifications or Deletions of Standardized Language:

  - *Correct minor grammatical or punctuation changes, update/correct phone numbers, and/or references).*
  - *Recreate graphics and/or tables, add plan logos, correct formatting (e.g., font style, margins), provided changes meet regulations at 42 C.F.R. §§ 422 Subpart V and 423 Subpart V, the CMS Medicare Communications and Marketing Guidelines (MCMG), and other CMS and state guidance. The standardized text must be used in the same order as the standardized material.*
  - *Correct web addresses or URLs if inaccessible or broken.*
  - *Delete plan instructions in blue text when populating the materials.*
  - *Modify, or delete, as necessary, all references to primary care providers (PCP), referrals, etc. if the organization uses an open access model.*
  - *Modify language related to network providers, as necessary, to clarify when a POS benefit may furnish coverage.*
  - *Change any references to Member Services to the term used by the plan.*
  - *Change references to TTY to TDD or TTY/TDD to reflect the correct communication technology.*
  - *Delete all step therapy references if any Part B and/or Part D drugs don't require step therapy.*
  - *Remove all ANOC references for new enrollees with effective dates of January 1 and later since only the EOC must be distributed to these enrollees.*
  - *Go to Appendix A for operational guidance.*]
- [*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 can choose to spell out terms each time they're 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 Medicaid 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 [*plans can add references to other behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports, as needed*]. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *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 <plan name>.

[*Plans that meet the 5% alternative language or Medicaid required language threshold insert:* This document is available for free in <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 doesn't need to make a separate request each time,* ***and***
- *how a member can change a standing request for preferred language and/or format.]*

[*Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that, at a minimum, states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge.*

The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in <State> and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.]

[*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), and included in any state-specific guidance provided by <Medicaid program name>*.]
- [*Consistent with the formatting in this section, plans can insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here.*]
- [*Update language as needed to reflect plan benefits.*] Benefits and/or copayments may change on January 1, 2028.
- [*Update language as needed to reflect plan benefits.*] Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about <plan name>, a health plan that [*insert description of the relationship such as covers or coordinates*] all of your Medicare and <Medicaid program name> services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *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 our plan

[*Insert language to describe the relationship between the Medicare and Medicaid services. For example:* Our plan provides Medicare and <Medicaid program name> 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 <Medicaid program name>

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. <Medicaid program name>

<Medicaid program name> is the name of <state> Medicaid program. <Medicaid program name> is run by the state and is paid for by the state and the federal government. <Medicaid program name> 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.

[*Plans can revise this section to best reflect the coverage of the plan in the state*.] Medicare and the state of <state> approved our plan. You can get Medicare and <Medicaid program name> services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of <state> allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and <Medicaid program name> services isn't affected.

C. Advantages of our plan

[*Plans can revise this section to best reflect the coverage of the plan in the state*.] You will now get all your covered Medicare and <Medicaid program name> services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and Medicaid 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.
- [*Insert the following paragraph if the Medicaid coverage start date could be different than the Medicare coverage start date:* New members to <plan name>: In most instances you'll 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 <insert

Medicaid program name> from your previous <insert Medicaid program name> health plan for one additional month. After that, you'll receive your <Medicaid program name> services through <plan name>. There will be no gap in your <Medicaid program name> coverage. Please call us at the number at the bottom of the page 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.*

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 included, for example: Our service area includes all parts of <county> within the following ZIP code(s): <ZIP code(s)>.

If needed, plans can insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that's easy to understand.]

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *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're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **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 <Medicaid program name>, and
- [*Insert any Medicaid requirements*].
- [*Insert if not covering Medicaid benefits during a deemed continued eligibility period:* If you lose your <Medicaid program name> within the [*Enter plan deeming period. Plans can choose any length of time from one to six months for deemed continued eligibility, as long as the plan applies the criteria consistently across all members and fully informs members of the policy*]-month period of deemed continued eligibility, we'll continue to

provide all Medicare Advantage plan-covered Medicare benefits. However, your <Medicaid program name> coverage may end sooner than your Medicare coverage with us. When your <Medicaid program name> coverage ends, we won't pay for your <Medicaid program name> benefits. [*Describe impact on Medicare cost-sharing, if any, during the period.*]

We'll assist you to regain your <Medicaid program name> eligibility. If your <Medicaid program name> eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your <Medicaid program name> benefits and your enrollment with us will continue. If you regain <Medicaid program name> eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.]

[*Insert if covering Medicaid benefits during deemed continued eligibility period:* If you lose your <Medicaid program name>, within the [*Enter plan deeming period. Plans can choose any length of time from one to six months for deemed continued eligibility, as long as the plan applies the criteria consistently across all members and fully informs members of the policy*]-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage and <Medicaid program name> plan-covered benefits. During this time, we'll assist you to regain <Medicaid program name> eligibility. If you regain <Medicaid program name> eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.]

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 [*Plans adjust this language if the state requirement is more stringent*].

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 [*add additional areas covered by HRA*].

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.

[*Plans can add additional language regarding information about joining the plans as directed by the state such as information about a continuity of care period or using doctors for a transition period*.]

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 [*Insert as applicable:* 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. Summary of Important Costs

[*Plans should revise this section to only include premium types that apply, delete the portions of Section H that aren't 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**)
- Medicare Prescription Payment Plan Amount (**Section H4**)

In some situations, your plan premium could be less.

[*Insert as appropriate, depending on whether State Pharmaceutical Assistance Programs (SPAPs) are discussed in* ***Chapter 2***: There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and SPAPs. OR The "Extra Help" program helps people with limited resources pay for their drugs.] Learn more about [*insert as applicable:* these programs OR this program] in **Chapter 2, Section H2**. If you qualify, enrolling in the program might lower your monthly plan premium.

If you already get help from [*insert as applicable:* these programs OR this program], **the information about premiums in this *Member Handbook*** [*insert as applicable**:*** may OR doesn't] **apply to you.** [*If not applicable, omit information about the LIS Rider.*] We [*insert as appropriate:* have included OR sent you] a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services at the number at the bottom of this page and ask for the "LIS Rider".

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", Medicaid).*]

As a member of your plan, you pay a monthly plan premium. [*Select one of the following:* For 2027, the monthly premium for [insert *2027* plan name] is [*insert monthly plan premium amount*]]. OR The monthly premium amount for [*insert 2027 plan name*] is listed in [*describe attachment*.] [*Plans can insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans can 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 can describe the benefit within this section*.]

[*Plans that don't 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 plan 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 to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both

Medicare Part A and Medicare Part B. For most <plan name> members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Medicare Part B. You may also pay a premium for Medicare Part A if you 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

[*Plans with no optional supplemental benefits should delete this section and renumber the remaining sections*.]

If you signed up for extra benefits, also called "optional supplemental benefits", 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*.]

H4. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from our plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2 [*insert reference, as appliable*] tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. This *Member Handbook*

This *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 this *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 URL 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're enrolled in our plan between <start date> and <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 *Drug List* or *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and <Medicaid program name> 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'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your <Medicaid program name> 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. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out what to do if you get a bill from a provider.

[*If members must use a different card for any Medicaid services, include a description here*.]

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 URL if different than the one in the footer or insert:* the web address at the bottom of the page].

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

[*Plans can add information describing the use of providers during a transition period as directed by the state*.]

Definition of network providers

- Our network providers include:
    - o doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - o clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - o [*Insert as applicable*: 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 Medicaid.]

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):*

List of Durable Medical Equipment (DME)

[*Insert as applicable:* We included 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 this *Member Handbook* to learn more about DME equipment.]

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless

they've been removed and replaced as described in **Chapter 5, Section <insert section>.** Medicare approved the <plan name> *Drug List.*

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 this *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. [*Plans can insert information about Medicaid covered drugs*.]

J4. The *Explanation of Benefits*

When you use your Medicare Part D drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D 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 drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't 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 this *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 can 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.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or 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**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, 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 can describe that option here*.]

[*Plans can add information regarding keeping their Medicaid information updated as directed by the state*.]

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 this *Member Handbook*.