**<Member #>**

**<Rx ID>**

**<Rx GRP>**

**<Rx BIN>**

**<Rx PCN>**

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

**Important: You have been enrolled in a new plan for your Medicare and Illinois Medicaid services. Keep this letter as proof of your coverage.**

<Name>:

**Welcome to <plan name> (Medicare-Medicaid Plan)!**

Starting <**effective date**>, you will have a health plan designed to give you seamless, high quality care at a low cost or zero cost to you. <Plan name> is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Your new coverage includes:

* Your choice of doctors, pharmacies and other providers within the plan’s network who work together to give you the care you need
* Prescription drugs
* Long-term services and supports to help you with an ongoing medical condition (Long-term services and supports are often provided in your home or a community setting so you don’t have to go to a nursing home or hospital.)
* [*If applicable, insert:* Extra benefits and services, including a care coordinator [*Plans may insert:* and other covered services such as dental, vision, etc*.*]]
* Durable Medical Equipment

**This letter is proof of your new coverage. [***Plan that does not include the Member ID Card in the welcome mailing should insert:* **Please bring this letter with you to the pharmacy or office visit until you receive your Member ID Card from us.**] If you have questions, call <plan name> Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free number>.

You may begin using <plan name> network primary care providers and pharmacies for all of your health care services and prescription drugs as of <**effective date**>. If you need emergency or urgently needed care,or out-of-area dialysis services, you can use providers outside of <plan name>’s network.

To help with the transition to <plan name>, if you are under a current course of treatment you can continue seeing the providers you go to now for 180 days [*plans can change this to 90 days if the enrollee is coming from another MMP plan*]. You will also have access to at least one [*must be at least 30*]-day supply of the Part D drugs you currently take during your first [*must be at least 90*] days in the plan and you will have access to the Medicaid-covered drugs you currently take during your first 180 days [*plans can change this to 90 days if the enrollee is coming from another MMP plan*] in the plan if you are taking a drug that is not our List of Covered Drugs, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires prior approval by <plan name>.

[*Plans may insert the following if they elect to not include the new member kit with the welcome mailing:* You will receive new member kit information separately*.*]

**The new member kit includes:**

* Summary of Benefits
* List of Covered Drugs (Formulary)
* Provider and Pharmacy Directory [*Plans may delete and replace with the following sentence if they elect not to send the Provider and Pharmacy Directory to enrollees*: Instructions for getting more information about the providers and pharmacies in our network]
* [*Plans may insert the following if they elect to include the Member ID Card with the welcome mailing*: Member ID Card]
* [*Plans may insert the following if they elect to include the Member Handbook with the welcome mailing*: Member Handbook (Evidence of Coverage)]

[*If the plan elects to send the Member ID Card and Member Handbook separately from the welcome mailing, the plan must insert the following*: Before <**enrollment effective date**>, we will send you [a Member ID Card] [and] [a Member Handbook (Evidence of Coverage)].]

**How much will I have to pay for <plan name>?**

You will not have to pay a plan premium, deductible, or copayments when receiving health services through a <plan name> provider.

**How much do I have to pay for prescription drugs?**

[*If plan has any Part D cost sharing, insert the following paragraph and include LIS cost sharing information specific to the enrollee’s LIS level:* When you pick up your prescription drugs at our network pharmacy, you’ll pay no more than <$\_\_\_ > each time you receive a generic drug that’s covered by <plan name> and no more than <$\_\_\_> each time you receive a brand name drug that is covered by <plan name>. Copayments for prescription drugs may vary based on the level of Extra Help you receive. Please contact <plan name> for more details.]

[*If plan has any Medicaid cost sharing, insert copayment information here*.]

[*If plan has no cost sharing for all Part D and/or Medicaid drugs, insert*: You pay $0 for <all or the rest of> your prescription drugs covered by the plan.]

[*If applicable, insert:*

**How can I switch my primary care provider?**

*Information instructing member in simple terms how to switch primary care provider/site, how to obtain services, which services do not need primary care provider’s approval (when applicable), etc.*]

**What if I have questions about <plan name>’s coverage?**

* Call <plan name> <Member Services> at <toll-free number>, <days and hours of operation>.
* Call <toll-free number> if you use TTY.
* Visit <web address>.

**What if I have other health or prescription drug coverage?**

If you have other health or drug coverage, such as from an employer or union, you or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>. Other types of health and drug coverage include TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Contact your benefits administrator if you have questions about your coverage.

**What if I don’t want to join <plan name>?**

You will be enrolled in <plan name> unless you cancel the enrollment before <**enrollment effective date**>. You can call 1-877-912-8880 (TTY: 1-866-565-8576), Monday to Friday from 8 a.m. to 7 p.m. and Saturday from 9 a.m. to 3 p.m. to cancel your enrollment with <plan name>. The call is free!

**What if I want to join a different Medicare-Medicaid plan?**

You should call 1-877-912-8880 (TTY: 1-866-565-8576), Monday to Friday from 8 a.m. to 7 p.m. and Saturday from 9 a.m. to 3 p.m. to join another Medicare-Medicaid plan. The call is free!

**Can I leave <plan name> or join a different plan after <effective date>?**

**Yes.** You may leave <plan name> or choose a new Medicare-Medicaid plan **at any time** by calling 1-877-912-8880 (TTY: 1-866-565-8576), Monday to Friday from 8 a.m. to 7 p.m. and Saturday from 9 a.m. to 3 p.m. If you choose to leave <plan name> and don’t want Illinois to enroll in another Medicare-Medicaid Plan, your coverage will end the last day of the month after you tell us you want to leave.

If you leave <plan name> and don’t join a Medicare health or prescription drug plan, you’ll be covered under Original Medicare and Medicare will enroll you in a Medicare prescription drug plan.

**How can I contact Medicare?**

If you want to join a Medicare health or prescription drug plan, want to know more about Medicare plans in your area, or have questions about Medicare:

* Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.
* Call 1-877-486-2048 if you use TTY.
* Visit the Medicare home page at http://www.medicare.gov.

**Who should I call if I have questions about Medicaid?**

If you have questions about **Illinois Medicaid**, call 1-877-912-8880 (TTY: 1-866-565-8576), Monday to Friday from 8 a.m. to 7 p.m. and Saturday from 9 a.m. to 3 p.m. The call is free!

[*Plans should include the following paragraph if they intend to conduct early HRS or HRAs:*

**What happens next?**

Someone from our health plan will call you to talk about your health and service needs before your services start on <**enrollment effective date**>. You can choose to wait until your services start before answering these questions. If you choose to wait, we will set a time after your enrollment date to discuss your health and service needs.]

You can get this information in Spanish, or speak with someone about this information in other languages, for free. Call [*insert Member Services phone and TTY/TDD numbers, and days and hours of operation*]. The call is free. [*The previous sentences must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]

This information is available for free in other languages and formats like large print, braille, or audio. Call [*insert Member Services phone and TTY/TDD numbers, and days and hours of operation*]. The call is free.