<Date>

<Name>

<Address>

<City>, <State> <ZIP>

**Member ID: <Member #>**

**Rx ID: <RxID>**

**Rx GRP: <RxGRP>**

**Rx BIN: <RxBIN>**

**Rx PCN: <RxPCN>**

**Important: You have been enrolled into a new MyCare Ohio Managed Care Plan for your Medicare and Medicaid Services. Keep this notice 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 must insert Federal-State contracting disclaimer from State-specific Marketing Guidance*.]

You’ll get a <plan name> Member Identification (ID) Card in the mail. If you haven’t gotten your Member ID Card by your effective date, you can show this letter to your doctors or pharmacy when getting services.

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
* For those who are eligible, long-term services and supports (Long-term services and supports include services for a long-term medical condition so you don’t have to go to a nursing home or hospital.)
* [*If applicable, insert:* Extra benefits and services, including a care manager [*Plans may insert:* and other covered services such as dental, vision, etc*.*]]
* Durable Medical Equipment, like [*Plan must insert two or three examples of covered items, such as crutches, walkers, wheelchairs, oxygen equipment, hospital beds, speech generating devices, nebulizers, intravenous (IV) infusion pumps.*]
* Behavioral Health Services

**What do I need to know about my new plan?**

<Plan name> will pay for medically necessary health care and prescription drug services from <plan name> providers. **Except as indicated below**, starting <**effective date**>, you must use a <plan name> provider for all your health services. You must also use a <plan name> pharmacy to get your medications. This means:

* If you need a provider who isn’t in <plan name>’s network, you must have “prior authorization” (PA) if you want <plan name> to cover the services. PA means that <plan name> gives you permission to use a provider who isn’t in <plan name>’s network.
* You don’t need PA for certain out-of-network providers until after your “transition period.” Please refer to the attached Transition of Care Time Period chart for more information.
* Emergency care, urgent care, federally qualified health centers, rural health clinics, qualified family planning providers, [*plans insert any other applicable providers for example if not in network*: [and] certified nurse midwives [and] certified nurse practitioners] are covered even if you use an out-of-network provider. You can read your *Member Handbook* or contact Member Services at <phone and TTY numbers>, <days and hours of operation> for more information.
* You will be asked to choose a primary care provider (PCP). Your PCP will be available to treat you for most of your health care needs. Your PCP must be part of <plan name>’s provider network.
* You will also have access to a <*supply limit (must be the number of days in a plan’s one-month supply)*>-day supply of prescription drugs you currently take during your first <*must be at least 90*>days in <plan name> if you are taking a drug that is not on 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 PA.

**How much do I have to pay for health services?**

You don’t have to pay a deductible or coinsurance amount when getting health services through <plan name>. [*Insert if applicable*: You will have to pay a copay when you have a prescription filled.]

[*Insert if applicable*: **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 <**$\_\_\_**> each time you get a generic drug that’s covered by <plan name> and no more than <**$\_\_\_**> each time you get a brand name drug that is covered by <plan name>. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact <plan name> at <phone and TTY numbers>, <days and hours of operation> for more details.]

[*If plan has any Medicaid cost sharing, insert copay 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.]

**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 do I need as a new member?**

As a new member you will get the following information from <plan name>:

* Before your enrollment effective date, you will get a Member ID Card that lists the name and telephone number of your primary care provider (PCP). If you don’t want the PCP listed on your Member ID Card, you can contact Member Services at <toll-free phone and TTY numbers>, <days and hours of operation> and ask to change your PCP. **You will need to show your <plan name> Member ID Card to get health care services.**
* [*Insert as applicable*: Enclosed is ***or*** We have sent] a Summary of Benefits. It gives an overview of your benefits under <plan name>, including information about copays, conditions, and limitations. The benefit information is a brief summary, not a complete description. For more information, contact the plan or read the *Member Handbook*.
* A *Provider and Pharmacy Directory* that lists the names of the providers and pharmacies that are part of <plan name>’s network. [*For plans that send a printed Provider and Pharmacy Directory to all new members, insert as applicable*: Enclosed is ***or*** We have sent <plan name>’s *Provider and Pharmacy Directory*]. [*For plans that do not send a printed Provider and Pharmacy Directory to all new members insert*: If you asked for a printed *Provider and Pharmacy Directory* when you called the Medicaid Hotline to select a MyCare Ohio managed care plan, [*insert as applicable*: enclosed is ***or*** we have sent] the directory.] If you did not contact the Medicaid Hotline to select a plan and you want a printed *Provider and Pharmacy Directory*, you can call Member Services. [*Plans may insert any additional ways members can request a printed Provider and Pharmacy Directory – for example return enclosed post card, through on-line website, etc.*] Members can always view up-to-date provider and pharmacy network information on our website at <URL> or call Member Services for help at <toll-free phone and TTY numbers>, <days and hours of operation>.
* A *List of Covered Drugs* (Formulary). 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. [*For plans that send a printed List of Covered Drugs to all new members, insert as applicable*: Each year, we will send you a copy of the *Drug List*, but some changes may occur during the year.] [*For plans that do not send a printed List of Covered Drugs to all new members insert*: If you asked for a printed *Drug List* when you called the Medicaid Hotline to select a MyCare Ohio managed care plan, [*insert as applicable*: enclosed is ***or***we have sent] the *Drug List*. If you did not contact the Medicaid Hotline to select a plan and you want a printed *Drug List*, you can call Member Services at <phone and TTY numbers>, <days and hours of operation>.] [*Plans may insert any additional ways members can request a printed List of Covered Drugs – for example return enclosed post card, through on-line website, etc.*] To get the most up-to-date information about which drugs are covered, visit <URL> or call <toll-free phone and TTY numbers>, <days and hours of operation>.
* [*Insert this section if plan limits DME* *brands and manufacturers*] [*Insert as applicable*: Enclosed is ***or*** We have sent] a list of durable medical equipment (DME). The 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 <URL>.
* [*Insert if plan elects to send a printed Member Handbook*: Enclosed is ***or*** We have sent] a *Member Handbook* [*for members enrolled in a MyCare Ohio Waiver insert*: and a Home and Community-Based Services Waiver Member Handbook]. It is very important that you read your *Member Handbook*, as it gives you a lot of information you need to know as a <plan name> member. [*For* *members enrolled in MyCare Ohio Waiver insert*: Your Waiver Member Handbook provides information specific to your waiver services.]

[*If plan elects not to send the Member Handbook to enrollees, insert:*An up-to-date copy of the *Member Handbook* (*Evidence of Coverage*) is always available on our website at <URL>. You may also call Member Services at <toll-free number> to ask us to mail you a *Member Handbook*.]

If you do not get the above information or do not understand the information, please contact <plan name>’s Member Services for help at <toll-free phone and TTY numbers>, <days and hours of operation>.

**What if I need help getting to my providers?**

[*Plans that provide transportation as an additional benefit, insert the following paragraph:*] If you **must** travel 30 miles or more from your home to get covered health care services, <plan name> will provide transportation. In addition we also provide [*insert a brief explanation of additional transportation provided*] as explained in your *Member Handbook*.Whenyou are a member, you can call <toll-free phone and TTY numbers>, <days and hours of operation> [*include any advance notification requirements*] to schedule transportation.

[*Plans that do not provide transportation as an additional benefit, insert the following paragraph:*] If you **must** travel 30 miles or more from your home to get covered health care services, <plan name> will provide transportation. Whenyou are a member, you can call <toll-free phone and TTY numbers>, <days and hours of operation> [*include any advance notification requirements*] to schedule a ride to and from your provider’s office.

Because you are eligible for Medicaid, you can also contact your County Department of Job and Family Services and ask for transportation assistance through the Non-Emergency Transportation (NET) program.

**What if I don’t want <plan name> for my Medicare services?**

You will be enrolled in <plan name> for both Medicare and Medicaid unless you cancel your enrollment for Medicare before <**enrollment effective date**>. If you do not want <plan name> to provide your Medicare benefits, you must call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Call Ohio Relay Service at 7-1-1 if you are hearing impaired.

You can also 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. Tell the representative that you do not want Ohio to enroll you in <plan name> for your Medicare services.

**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 during the year by calling the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Call Ohio Relay Service at 7-1-1 if you use TTY.

If you don’t want to get your Medicare benefits, including Part D prescription drugs, through a MyCare Ohio plan, your Medicare coverage with <plan name> will end the last day of the month after you tell us you want to make the change. If you end your Medicare services in <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.

You must get your Medicaid benefits from a MyCare Ohio managed care plan. Even if you don’t want to get your Medicare benefits through a MyCare Ohio plan, you must still get your Medicaid benefits from <plan name> or another MyCare Ohio managed care plan.

**What if I have questions?**

* For questions about **<plan name> or this notice**, call Member Services at <toll-free phone and TTY numbers>, <days and hours of operation>, or visit <URL>.
* For questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048), 24 hours a day, 7 days a week, or visit the Medicare home page at [www.medicare.gov](http://www.medicare.gov).
* For questions about **the MyCare Ohio program**, call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Call Ohio Relay at 7-1-1 if you use TTY or visit [www.ohiomh.com](http://www.ohiomh.com).
* For questions or concerns about **any aspect of care available through the MyCare Ohio program**, call the Office of the State Long-Term Care Ombudsman (1-800-282-1206) (TTY Ohio Relay Service: 1-800-750-0750), Monday through Friday from 8:00 am to 5:00 pm or email [MyCareOmbudsman@age.ohio.gov](mailto:MyCareOmbudsman@age.ohio.gov). The Office of the State Long-Term Care Ombudsman is a consumer advocacy program.

If you have a problem reading or understanding this information, please contact <plan name>’s Member Services for help, at no cost to you. We can explain this information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

[*Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>. The call is free.

***(Dual Benefits New Member Letter - This information must be on a separate page)***

**Very Important Information**

For a specified time period after enrolling in the MyCare Ohio program to get both your Medicare and Medicaid benefits, you are allowed to get services from certain out-of-network providers and/or finish getting services that were authorized by Ohio Medicaid. This is called your transition of care time period.

**Please note, the transition periods below start on the first day you are effective with any MyCare Ohio managed care plan to get both your Medicare and Medicaid benefits. If you change your MyCare Ohio managed care plan, your transition period for coverage of a non-network provider does not start over.**

If you were getting the following Medicare or Medicaid services at the time of your enrollment in a MyCare Ohio managed care plan, it is important that you call Member Services **immediately** (today or as soon as possible) to prevent any access or billing issues.

[*Insert the applicable chart below depending on whether or not the member is enrolled in the MyCare Ohio waiver.*]

[*Chart for dual benefits non-waiver members:*]

**Transition of Care Time Period**

For members getting both Medicare and Medicaid benefits

through their MyCare Ohio managed care plan

| Service | Services you were getting from a non-network provider at the time of your enrollment in the MyCare Ohio program will be covered from the first date of enrollment for: |
| --- | --- |
| * Physician * Community Mental Health * Addiction Treatment Centers | 365 days except if you are identified for high risk care management then your physician must be covered for 90 days. |
| Dialysis Treatment | 90 days (or more if authorized by plan). |
| * Ohio Medicaid Prior authorized Durable   Medical Equipment, Vision and Dental   * Scheduled Surgery * Chemotherapy/Radiation * Organ/Bone Marrow/Hematopoietic Stem Cell Transplant | Until you get the planned or authorized services. |
| Medicaid Home Health and Private Duty Nursing | 90 days. |
| Assisted Living or Medicaid Nursing Facility | Unlimited period if lived in the facility on the day you enrolled in the MyCare Ohio program and the service continues to be medically necessary. |

[*Chart for dual benefits waiver members:*]

**Transition of Care Time Period**

For members getting both Medicare and Medicaid benefits

through their MyCare Ohio managed care plan

| Service | Services you were getting from a non-network provider at the time of your enrollment in the MyCare Ohio program will be covered from the first date of enrollment for: |
| --- | --- |
| * Physician * Community Mental Health * Addiction Treatment Centers | 365 days except if you are identified for high risk care management then your physician must be covered for 90 days. |
| Dialysis Treatment | 90 days (or more if authorized by plan). |
| * Ohio Medicaid Prior authorized Durable Medical Equipment, Vision and Dental * Scheduled Surgery * Chemotherapy/Radiation * Organ/Bone Marrow/Hematopoietic Stem Cell Transplant | Until you get the planned or authorized services. |
| Medicaid Home Health and Private Duty Nursing | 365 days unless a change is required due to a health or other life event that changes your needs. |
| Waiver Services – Direct Care including:   * Personal Care * Waiver Nursing * Home Care Attendant * Choice Home Care Attendant * Out of Home Respite * Enhanced Community Living * Adult Day Health * Social Work Counseling * Independent Living Assistance | 365 days unless a change is required due to a health or other life event that changes your needs. |
| All other waiver services | 90 days and only after an in-home assessment is completed to transition your services to a new provider. (The services amount is maintained for 365 days.) |

[*Insert as last paragraph of letter if plan requires PA for any medications:*] <Plan name> will tell you if any of your current medications require PA the first time you fill the medication. **If your medication(s) requires PA, you cannot get the medication(s) until your provider submits a request to <plan name> and it is approved.**