| <Date>  <Name>  <Address>  <City>, <State> <ZIP> | **Member ID: <Member #>**  **Rx ID: <RxID>**  **Rx GRP: <RxGRP>**  **Rx BIN: <RxBIN>**  **Rx PCN: <RxPCN>** |
| --- | --- |

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

<Name>:

**Welcome to <plan name> (a 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. <Insert Federal-State contracting disclaimer from the State-specific Marketing Guidance>.

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 (Long-term services and supports include services for a long-term medical condition, like personal attendant services, so you don’t have to go to a nursing home or hospital.)
* Extra benefits and services, including a service coordinator [*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.*]

**This letter is proof of your new coverage.** [*Plans that do 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 get your Member ID Card from us.**] If you have questions, call <plan name> Member Services at <toll-free phone and TTY numbers>, <days and hours of operation>.

**What happens next?**

Except as described below, you must begin using <plan name> network primary care providers and pharmacies for all of your medical 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>, you may be able to keep seeing the providers you go to now for at least 90 days. You will also have access to a [*insert supply limit* (*must be the number of days in plan’s one-month supply)*]-day supply of the Part D drugs you currently take during your first 90 days in the plan if:

* you are taking a drug that is not on our *List of Covered Drugs*,
* health plan rules do not let you get the amount ordered by your doctor, or
* the drug requires prior approval by <plan name>.

[*Plans may insert the following if they don’t elect to include the new member kit with the welcome mailing:* You will get a new member kit with information separately*.*]

**The new member kit includes:**

* *List of Covered Drugs* (Formulary) [*Plan may delete and replace with the following if it elects not to send List of Covered Drugs to enrollees:* Instructions for getting more information about the drugs on our *List of Covered Drugs*]
* *Provider and Pharmacy Directory* [*Plans may delete and replace with the following if they don’t elect 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)]
* [*Plans may insert the following if they elect to include the Summary of Benefits with the welcome mailing*: Summary of Benefits]

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

[*Plan may insert the following if it sends the Member Handbook separately from the welcome mailing:* Before <**enrollment effective date**>, we will send you a *Member Handbook* (Evidence of Coverage).]

[*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 <web address>. You may also call Member Services at <toll-free number> to ask us to mail you a *Member Handbook.*]

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

You will not have to pay a plan premium, deductible, or copays when getting medical services through a <plan name> provider.

**How much will 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> for more details.]

[If plan has any Texas Medicaid cost sharing, insert copay information here.]

[If plan has no cost sharing for all Part D and/or Texas 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 choose a primary care provider?**

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

**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 want to join a different Medicare-Medicaid Plan?**

To join another Medicare-Medicaid Plan, call the STAR+PLUS help line at 1-877-782-6440, Monday-Friday, 8 a.m. to 6 p.m. Central Time. If you have a speech or hearing disability, call 7-1-1 or 1-800-735-2989.

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

[Plans in states that continue to implement a continuous Special Enrollment Period for dual eligible members (duals SEP) insert: **Yes.** You may leave <plan name> or choose a new Medicare-Medicaid Plan **at any time during the year** by calling the STAR+PLUS help line at 1-877-782-6440. You can call Monday-Friday, 8 a.m. to 6 p.m. Central Time. If you have a speech or hearing disability, call 7-1-1 or 1-800-735-2989.]

[Plans in states that implement the duals SEP effective 2020, insert: Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

* January to March
* April to June
* July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

* The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in <plan name> will end on December 31 and your membership in the new plan will start on January 1.
* The **Medicare Advantage Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan will start the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. If you want to make a change, call the STAR+PLUS help line at 1-877-782-6440, Monday-Friday, 8 a.m. to 6 p.m. Central Time. If you have a speech or hearing disability, call 7-1-1 or 1-800-735-2989.]

If you leave <plan name> and don’t want to enroll in another Medicare-Medicaid Plan, your coverage will end the last day of the month after you tell us.

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.

**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 <web address>.
* For questions about **other enrollment choices**, call a State Health Insurance Assistance (SHIP) counselor at 1-800-252-3439 (TTY: <insert TTY number>), <days and hours of operation>.
* For questions about **coverage decisions, appeals, or complaints**, call the HHSC Office of the Ombudsman at 1-866-566-8989 (TTY: 1-800-735-2989), <days and hours of operation>.
* 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 <http://www.medicare.gov>.
* For questions about **Texas Medicaid**, call 1-800-252-8263 (TTY: <insert TTY number>), <days and hours of operation>.

[Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to[*https://www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call [insert Member Services toll-free phone and TTY numbers, and days and hours of operation]. The call is free. [Plans must provide the information in alternate formats when a Member requests it or when the plan identifies a Member who needs it.]