**Exhibit 5a: MMP Welcome Letter for Passively Enrolled Individuals**

<Date>

**<Member # >**

**<RxID>**

**<RxGroup>**

**<RxBin>**

**<RxPCN>**

<Name>

<Address>

<City>, <State> <ZIP>

**IMPORTANT: YOU HAVE BEEN ENROLLED INTO A NEW MYCARE OHIO MANAGED CARE PLAN FOR YOUR MEDICARE AND MEDICAID SERVICES.**

<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 Ohio Medicaid to provide benefits of both programs to enrollees. You’ll get a <plan name> member identification (ID) card in the mail. If you have not received 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 coordinator [*Plans may insert:* and other covered services such as dental, vision, etc*.*]]
* Durable Medical Equipment
* 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 see 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 to see a provider who isn’t in <plan name>’s network, you must have “prior authorization” if you want <plan name > to cover the services. “Prior authorization” means that <plan name> gives you permission to see a provider who isn’t in <plan name>’s network.
* You don’t need prior authorization for certain out-of-network providers until after your “transition period.” Please see 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 see an out-of-network provider. You can read your Member Handbook or contact <Member Services> 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 at least one [*must be at least 30*]-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 prior approval.

**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 copayment when you have a prescription filled.]

[*Insert if applicable*:] **How much do I have to pay for prescription drugs?**

[*Plans may delete the following sentence if they have $0 copayments for all Part D drugs*:] Copayments for prescription drugs may vary based on the level of Extra Help you receive. Please contact <plan name> for more details. [*Plans must insert LIS cost sharing information specific to the enrollee’s LIS level in the following sentence:*] When you pick up your prescription drugs, you’ll pay no more than <$\_\_\_ > each time you receive a generic drug that is covered by <plan name>, and no more than <$\_\_\_> each time you receive a brand name drug that is covered by <plan name>.

**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 receive the following information from <plan name>:

* Prior to your enrollment effective date, you will receive a member identification (ID) card that lists the name and telephone number of your primary care provider (PCP). If you don’t want the PCP that is listed on the ID card, you can contact <Member Services> and ask to change your PCP. **You will need to show your <plan name> member ID card to receive health care services.**
* [*Insert as applicable*: Enclosed is *or* We have sent] a Summary of Benefits. It provides 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.
* [*Insert as applicable*: 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.]
* 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 requested 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 <website address> or call <Member Services> for assistance.
* [*Insert as applicable*: Enclosed is *or* We have sent] 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. 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>.
* [*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. The list tells you the brands and makers of durable medical equipment that we cover. The most recent list of brands, makers, and suppliers is also available on our website at <website address>.

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

**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 receive 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 <telephone numbers> [*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 receive covered health care services, <plan name> will provide transportation. Whenyou are a member you can call <telephone numbers> [*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>. To cancel your enrollment for Medicare, you must call the Ohio Medicaid 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. TTY users should call Ohio Relay Service at 7-1-1. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048). 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 MyCare Ohio plan **at any time** by calling the Ohio Medicaid 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. TTY users should call Ohio Relay Service at 7-1-1.

If you don’t want to receive 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. If you have questions about Medicare plans in your area, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week or visit http://www.medicare.gov. TTY users should call 1-877-486-2048.

You must receive your Medicaid benefits from a MyCare Ohio managed care plan. Therefore, even if you don’t want to receive 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.

**Who should I call if I have questions about <plan name>?**

If you have questions, call <plan name> <Member Services> at <toll-free phone number> <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>.

You can also call the Ohio Medicaid 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. TTY users should call the Ohio Relay Service at 7-1-1.

**If you have questions about Medicare, Medicaid, or the MyCare Ohio program**

If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit http://www.medicare.gov. TTY users should call 1-877-486-2048.

If you have questions about Medicaid or the MyCare Ohio program, call the Ohio Medicaid 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. TTY users should call Ohio Relay Service at 7-1-1. You can also visit http://www.medicaid.ohio.gov.

If you have a problem reading or understanding this information, please contact <plan name> <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.

[*The following disclaimer 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.*]You can get this information for free in other languages. Call <toll-free number>. The call is free.

This information is available for free in other languages and formats, like Braille and audio CD.

***(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 receive both your Medicare and Medicaid benefits, you are allowed to receive services from certain out-of-network providers and/or finish receiving 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 receive 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 receiving 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 receiving both Medicare and Medicaid benefits

through their MyCare Ohio managed care plan

| Service | Services you were receiving 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 the planned or authorized services are received. |
| 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 receiving both Medicare and Medicaid benefits

through their MyCare Ohio managed care plan

| Service | Services you were receiving 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 the planned or authorized services are received. |
| 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 prior authorization the first time you fill the medication. If your medication(s) requires prior authorization, you cannot get the medication(s) until your provider submits a request to <plan name> and it is approved.