[If the plan uses the Member’s Medicaid ID# as its Member’s Plan ID#, replace the two fields Member ID and Beneficiary ID with one field,Member/Beneficiary ID.]

<Date>

<Name>

<Address>

<City>, <State> <Zip>

**Member ID: <Member’s Plan ID#>**

**Beneficiary ID: <Member’s Medicaid ID#>**

**Rx ID: <RxID#>**

**Rx GRP: <RxGRP#>**

**Rx BIN: <RxBIN#>**

**Rx PCN: <RxPCN#>**

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

<Name>:

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

Starting <**effective date**>, you will have a health plan designed to give you more coordinated, high quality care at no cost to you. <Insert Federal-State contracting disclaimer from the State-specific Marketing Guidance>.

Your new coverage includes:

* One plan for all your Medicare and Michigan Medicaid provider and pharmacy benefits
* No copays, premiums, or deductibles when you get services from a provider or pharmacy in your health plan’s provider network (You are required to keep paying any monthly Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting [www.michigan.gov/mdhhs/0,5885,7-339-73970\_5461---,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html).)
* Your own Care Coordinator who will ask you about your health care needs and choices and work with you to create a personal care plan based on your goals
* Home and community-based supports and services to help you live independently
* Emergency or urgently needed care
* And other program benefits, such as increased access to dental and vision care

**What happens now?**

Except as described below, you must begin using <plan name> network of 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 if you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider.

* You can keep seeing doctors you go to now for at least 90 days from your enrollment start date. If your current providers are not part of <plan name>’s network, we will work to make them part of our network so you are able to continue seeing them after your first 90 days in <plan name>. Please contact Member Services at <toll-free phone and TTY numbers>, <days and hours of operation>, to see if your current providers are part of <plan name>’s network.
* You will keep seeing Prepaid Inpatient Health Plan (PIHP) network providers without change if you get services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP.
* You will be able to get services and see doctors and providers you go to now for your non-behavioral health services for up to 180 days from your enrollment start date. Your Care Coordinator will work with you to choose new providers and arrange services within this time.

You will also have access to a [insert supply limit (must bethe number of days in plan’s one-month supply)]-day supply of the drugs you currently take during your first [must be at least 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>.

**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.**]

[Plans may insert the following if they do not elect to include the new member kit with the welcome mailing:You will get new member kit 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 sentence if they do not elect to send the Provider and Pharmacy Directory to enrollees: Instructions for getting more information about the providers and pharmacies in our network]
* A letter for you to take with you to your provider appointments that explains your new benefit plan and what the provider should do
* [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 <MMP web address>. You may also call Member Services at <toll-free phone and TTY numbers> 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 copay when getting health services through a <plan name> provider.

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

<Plan name> members have no copays for prescription and over the counter (OTC) drugs.

**How do I choose a primary care provider?**

If you have not chosen a Primary Care Provider (PCP), we will help you find one within our provider network.

**How do I keep my current personal care provider?**

If you are getting personal care services through the Home Help program offered by the Michigan Department of Health and Human Services, you will begin getting these services through <plan name> on <**effective date**>. You may keep your current caregiver. **Please ask your caregiver to contact us** at [insert plan contact toll-free phone and TTY numbers, days and hours of operation] to ensure timely payment for services.

**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 sponsored plan, you can leave that coverage and enroll in MI Health Link**, but you or your dependents could lose coverage completely and not get it back if you join MI Health Link.** 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 current coverage.

**What if I want to join a different MI Health Link health plan?**

To join another MI Health Link health plan, call **Michigan ENROLLS toll-free at 1-800-975-7630**. Call 1-888-263-5897 if you use TTY. Office hours are Monday through Friday, 8 AM to 7 PM.

**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 <state/enrollment broker number>, <days and hours of operation>.]

[Plans in states that implement the dual*-eligible individual and other LIS-eligible individual quarterly* SEP effective 2021, insert:Most people with Medicare can end their membership 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 <state/enrollment broker number>, <days and hours of operation>.]

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

**What if I have questions?**

* For questions about **this notice or** **<plan name>’s coverage**, call <plan name> Member Services at <toll-free phone and TTY numbers>, <days and hours of operation>. You can visit <plan name’s MI Health Link web address>.
* For questions about **Medicare**, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit the Medicare home page at [www.medicare.gov](http://www.medicare.gov). Call 1-877-486-2048 if you use TTY.
* For questions about **Michigan Medicaid**, enrollment or disenrollment, call Michigan ENROLLS toll-free at 1-800-975-7630. Call 1-888-263-5897 if you use TTY. Office hours are Monday through Friday, 8 AM to 7 PM.
* For questions about **Medicare enrollment options**, call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. They are open Monday through Friday from 8 AM to 5 PM. The call is free.
* For **service or billing problems, or assistance with filing a complaint or an appeal** with our plan, call the MI Health Link Ombudsman program at 1-888-746-6456. Call 711 if you use TTY. Office hours are Monday through Friday, 8 AM to 5 PM. The MI Health Link Ombudsman is an independent program and the services are free.

[Plans should include the following paragraph if they intend to conduct early outreach:

**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.]

Sincerely,

<Plan name>

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

[*Plans may increase the font size and/or use bold font to emphasize the following information.*] 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, days and hours of operation]. The call is free.