**KEEP THIS NOTICE FOR YOUR RECORDS!**

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

**Participant ID: <Participant #>**

**Rx ID: <RxID>**

**Rx GRP: <RxGRP>**

**Rx BIN: <RxBIN>**

**Rx PCN: <RxPCN>**

[Note to plans on the Rx information above: *RxBIN is always required. RxPCN and RxGRP are required when needed by the drug plan. RxID is required only when different from the medical plan Cardholder ID#.*]

**IMPORTANT: YOU HAVE BEEN ENROLLED IN A NEW FULLY INTEGRATED DUALS ADVANTAGE (FIDA) PLAN FOR YOUR MEDICARE AND MEDICAID SERVICES.**

<Name>:

Welcome to <PLAN NAME> (Medicare-Medicaid Plan)!

Medicare and New York Medicaid told us that you will be in <plan name> beginning **<effective date>**. <Insert Federal-State contracting disclaimer from State-specific Marketing Guidance>.

[If the beneficiary is not joining the FIDA plan from an MLTC plan operated by the same parent organization, include the following paragraph:] A representative of <plan name> will reach out to you to schedule a time for a nurse to visit you to find out more about your medical, behavioral health service, home care, and other needs. We call this a “comprehensive assessment.”

[*Insert the following sentence for passively enrolled individuals if the plan will be doing pre-effective date assessments:* Please note that <plan name> may call to schedule your comprehensive assessment before your coverage starts on **<effective date>**. Participating in the assessment before **<effective date>** is voluntary.] Your participation in the comprehensive assessment is important so that we can make sure you have a seamless transition into <plan name>.

[If the beneficiary is joining the FIDA plan from an MLTC plan operated by the same parent organization, include the following paragraph:] A representative of <plan name> will reach out to you to welcome you to the plan. If it has been six months since your last assessment in <MLTC plan name>, the representative will also schedule a time for a nurse to visit you to complete a new comprehensive assessment. If it has been less than six months since your last assessment in <MLTC plan name>, you will not need a new assessment until six months has passed unless there have been any important changes in your health. Your participation in the comprehensive assessment is important so that <plan name> knows about all your needs.

<Plan name> will cover and pay for all of your Medicare and Medicaid services. You will not need to pay anything to <plan name> for participating or getting your FIDA services. However, if you have Medicaid with a “spend-down” or “excess income,” you will have to keep paying your spend-down to the FIDA plan. There is no monthly premium, no deductible, and no copay. With our plan, you will get:

* Your choice of doctors, pharmacies and other providers within the plan’s network;
* Hospital and rehabilitation services;
* Medicines (prescription and some over-the-counter drugs);
* Long-term services and supports including home care, adult day health care, and nursing home care;
* A care manager who will work with you and your care team to make sure you get all the Medicare and Medicaid services you need;
* [*Insert if applicable:* Extra benefits and services, including [*Plans may insert any supplemental benefits or services in addition to covered services that NYSDOH approved in the plan’s PBP submission*];]
* Dental, Vision, and Hearing services;
* Durable Medical Equipment, like [*Plans 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.*]
* Consumer Directed Personal Assistance Services; and
* Additional services, all of which are outlined in Chapter 4 of the *Participant Handbook* [*insert if the Participant Handbook is not included in this mailing:* that you will soon get].

**This letter is proof of your new coverage.** [*Plans that do not include the Participant ID Card in the welcome mailing should insert:* **Until you get your new Participant kit, use this letter as proof of your new coverage. Please take this letter with you to the pharmacy or office visit until you get your <plan name> Participant ID Card from us.**]

You may begin using <plan name> network providers and pharmacies for all of your services and prescription drugs as of **<effective date>**.

* You can use providers outside of <plan name>’s network if you need emergency or urgently needed care or out-of-area dialysis services.
* You can keep seeing the providers (including doctors and home care providers) you go to now for 90 days after **<effective date>** as you get used to our plan.
* 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 even if <plan name>:
  + does not cover them;
  + rules do not let you get the amount ordered by your doctor; or
  + usually requires that you get their permission before they pay for them.

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

**Your new Participant kit includes:**

* Summary of Benefits [*Plans may delete this bullet when this notice is sent to individuals who self-select into the plan. Note that plans must include the Summary of Benefits in the new Participant kit for individuals who are passively enrolled into the plan but are not required to include the Summary of Benefits for individuals who self-select into the plan.*]
* *List of Covered Drugs* (Formulary) [*Plans must insert: List of Covered Drugs* (Formulary) ***or*** A notice telling you how to get a *List of Covered Drugs* or access it online.]
* [*Plans must insert: Provider and Pharmacy Directory* ***or***A notice telling you how to get a *Provider and Pharmacy Directory* or access it online]
* [*Plans may insert the following if they elect to include the Participant ID Card with the welcome mailing*: Participant ID Card]
* [*Plans may insert the following if they elect to include the Participant Handbook with the welcome mailing*: *Participant Handbook* (Evidence of Coverage)]

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

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

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

How much do I have to pay for services?

You do not have to pay a plan premium, deductible or copays to get services from a <plan name> network provider.

How much do I have to pay for prescription and non-prescription drugs covered by <plan name>?

You do not have to pay a copay when you get covered drugs from a <plan name> network pharmacy.

[*Insert for Participants who haven’t chosen a PCP*:

**How can I choose a primary care provider (PCP)?**

Contact Participant Services at <toll-free number> (TTY: <toll-free TTY number>), <days and hours of operation> to choose your primary care provider (PCP). If you do not choose one, your PCP will be chosen for you. You can change your PCP at any time by calling <plan name> Participant Services.]

[*Insert for Participants who have chosen a PCP:*

**Who is my primary care provider (PCP)?**

We have been told that you wish to have <name of PCP> as your primary care provider (PCP). You can change your PCP at any time by contacting Participant Services at <toll-free number> (TTY: <toll-free TTY number>), <days and hours of operation>.]

**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 because of your joining <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.

[*Include the following language when this notice is sent to individuals who are passively enrolled into the plan*:

**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**>. To cancel your enrollment, you can call New York Medicaid Choice (NYMC) or you can call Medicare. Contact information is in the attached List of Resources. When you call, tell the representative that you do not want to be enrolled in a FIDA plan.]

**What if I want to join a different FIDA Plan or a Medicare health or drug plan?**

To join another FIDA Plan, call New York Medicaid Choice (NYMC). To join a Medicare health plan or Medicare prescription drug plan, call Medicare. Contact information is in the attached List of Resources.

**Can I leave <plan name> or choose a new plan after <effective date>?**

[*Plans in states that continue to implement a continuous Special Enrollment Period for dual eligible beneficiaries (duals SEP) insert:* **Yes.** You may leave <plan name> or choose a new FIDA Plan **at any time during the year** by calling New York Medicaid Choice (NYMC). Contact information is in the attached List of Resources.]

* If you call **before** <**effective date**>, NYMC can cancel your request to join the plan.
* If you call **after** <**effective date**>, you can leave <plan name> on the last day of the month you called NYMC.
  + If you leave <plan name> and do not join a Medicare health or prescription drug plan, you will need to use a red-white-and-blue Medicare card to get your Medicare services like doctor visits. Medicare will also sign you up for a Medicare prescription drug plan.
  + You will get your Medicaid services like home care, adult day care, or nursing home care from a Managed Long-Term Care (MLTC) plan.
* If you choose to change plans, you will be able to move to a different plan on the first day of the next month after you ask New York Medicaid Choice (NYMC) to change your plan.

[*Plans in states that implement the new duals SEP effective 2019, insert:* **Yes.** You may leave <plan name> or choose a new Medicare-Medicaid Plan before <**effective date of enrollment**>. You’ll also have from <**effective date of enrollment**> through <**three months after effective date of enrollment**> to change to another Medicare health plan.

If you don’t make a change during this time, you’ll be able to change plans during certain times of the year or in certain situations. Because you have Medicaid, you may be able to end your participation 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 participation 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 participation 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 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?**

The State of New York has created a Participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at [icannys.org](http://icannys.org/). (TTY users call 711, then follow the prompts to dial 844-614-8800.)

You can also review the attached List of Resources, which provides contact information for other organizations that can help.

Thank you.

<Plan Name>

[*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 Participant Services toll-free phone and TTY/TDD numbers and days and hours of operation*]. The call is free.

**List of Resources**

| **Resources** | Information |
| --- | --- |
| **<Plan Name>**  For questions about your plan coverage | Call: <toll-free number>  TTY users: <toll-free TTY number>  <days and hours of operation>  The call and the help are free.  Online: <website> |
| **New York Medicaid Choice**  For questions about the FIDA program and your Medicaid benefits | Call: 1-855-600-3432  TTY users: 1-888-329-1541  A free interpreter: 1-855-600-3432  Monday-Friday, 8:30 am – 8:00 pm  Saturday, 10:00 am – 6:00 pm  The call and the help are free.  Online: <https://www.nymedicaidchoice.com/> |
| **Medicare**  For questions about your Medicare benefits | Call: 1-800-MEDICARE (1-800-633-4227)  TTY users: 1-877-486-2048.  24 hours a day, 7 days a week  The call and the help are free.  Online: <https://www.medicare.gov/> |
| **Independent Consumer Advocacy Network (ICAN)**  For questions about your rights | Call: 1-844-614-8800  TTY users: 711, then follow the prompts to dial 844-614-8800  A free interpreter: 1-844-614-8800  Monday-Friday, 8:00 am – 8:00 pm  The call and the help are free.  Online: <http://icannys.org/> |