<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 plan for your Medicare and Medi-Cal Services. Keep this letter as proof of your coverage.**

<Name>:

**Welcome to <plan name>!**

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

Your new coverage includes:

* Your Medicare benefits, including prescription drugs
* Your Medi-Cal benefits, including long-term services and supports (LTSS) that help you with ongoing personal care needs. LTSS includes Multipurpose Senior Services Program (MSSP) and Community-Based Adult Services (CBAS), which are services that can help you stay in your home as long as possible. It also includes nursing home care if you need it.
* Your choice of doctors and other providers within our network who work together to give you the care you need
* [If applicable insert:Extra benefits and services such as vision care, transportation services and a care coordinator [plans may insert: and other covered services such as dental, vision, etc.]]
* 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.]

**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?**

You may begin using <plan name> network primary care 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 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 doctors you go to now for a period of up to twelve (12) months from the effective date of your enrollment in <plan name>. Contact <plan name> Member Services at <toll-free phone and TTY numbers>, <days and hours of operation> for information on how to do this.

You will also have access to a [insert supply limit (must bethe number of days in plan’s one-month supply)]-day supply of prescription 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*, if health plan rules do not let you get the amount ordered by your doctor, or if the drug requires prior approval by <plan name>.

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

**The new member kit includes:**

* Summary of Benefits
* *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 elect not 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)]

[If the plan elects to send the Member ID Card separately from the welcome mailing, the plan must insert the following: Before your enrollment 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).]

[Additionally, plan may 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 health services through a <plan name> provider.

**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’s 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 Medi-Cal 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.]

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

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

**Who should I call if I have questions about <plan name>’s coverage or providers?**

* Call <plan name> <Member Services> at <toll-free number> <days and hours of operation>.
* Call <toll-free number> if you use TTY.
* Visit <web address>.

**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 the benefits administrator of the other health/drug coverage if you have questions about your coverage.
* If you want to cancel your enrollment in <plan name>, you must call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. Call 1-800-430-7077 if you use TTY.

**What if I don’t want to join <plan name>?**

You will be enrolled in <plan name> unless you cancel your enrollment before <**enrollment effective date**>. To cancel your enrollment, you must call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. Call 1-800-430-7077 if you use TTY. Tell them that you do not want to enroll in <plan name>.

**Can I leave <plan name> 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 Cal MediConnect plan **at any time during the year** by calling <state/enrollment broker number>, <days and hours of operation>.]

[Plans in states that implement the duals SEP effective 2020, insert:**Yes.** You may leave <plan name> or choose a new Cal MediConnect 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 Medi-Cal, 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 don’t want to enroll in another Cal MediConnect 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 want to join a different Cal MediConnect plan?**

If you want to keep getting your Medicare and Medi-Cal benefits together from a single plan, you can join a different Cal MediConnect plan. To enroll in a different Cal MediConnect plan, call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. Call 1-800-430-7077 if you use TTY. Tell them you want to leave your current Cal MediConnect plan and join a different Cal MediConnect plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

**What happens to my Medicare if I leave <plan name>?**

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. If you want to join a Medicare health or prescription drug plan, want to know more about Medicare plans in your area, or have questions about Medicare:

* 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.
* Visit the Medicare home page at <http://www.medicare.gov>.

**What happens to my Medi-Cal if I leave <plan name>?**

You must have a Medi-Cal health plan in order to keep getting your Medi-Cal services, including long-term services and supports (LTSS) that help you with ongoing personal care needs. If you leave your Cal MediConnect plan, you will need to let Health Care Options know which Medi-Cal managed care plan you want to join.

To do so, call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. Call 1-800-430-7077 if you use TTY. Tell them you do not want to be enrolled in <plan name> and you want to join a Medi-Cal managed care plan. If you are not sure about which plan you want to join, they can tell you about other plans in your area.

**What if I need help or more information?**

* If you want to talk to a health insurance counselor about these changes and your choices, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222 <days and hours of operation>. Call <TTY number> if you use TTY.
* If you need help enrolling in a Cal MediConnect or Medi-Cal plan, call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. Call 1-800-430-7077 if you use TTY.
* If you are in a Cal MediConnect plan and need further help, call the Cal MediConnect Ombuds Program at 1-855-501-3077, <days and hours of operation>. Call <TTY number> if you use TTY.

[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).]

If you need this document in another language or alternate format, like large print, braille, or audio, or if you need help understanding this letter, please call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. Call 1-800-430-7077 if you use TTY. You can get this information for free.