<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 Illinois Medicaid services. Keep this letter as proof of your coverage.**

<Name>:

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

Starting <**effective date**>, you’ll have a health plan designed to give you seamless, high quality care at a low cost or zero cost to you. [*Plan must insert Federal-State contracting disclaimer from State-specific Marketing Guidance*.]

Your new coverage includes:

* Your choice of doctors, pharmacies and other providers in the plan’s network who work together to give you the care you need
* Prescription drugs
* Long-term services and supports to help you with an ongoing medical condition (Long-term services and supports are often provided in your home or a community setting so you don’t have to go to a nursing home or hospital.)
* Extra benefits and services, including a care coordinator to help you manage your health care and long-term services and supports [*Plan may insert as applicable:* 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.** [*Plan that does 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. Contact information is in the List of Resources at the end of this notice.

**What happens now?**

Except as described below, you must 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>, if you’re under a current course of treatment you can keep using the providers you use now for 180 days [*plan can change this to 90 days if the enrollee is coming from another health plan*].
* You’ll 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 [*must be at least 90*] days in the plan and you’ll have access to the Medicaid-covered drugs you currently take during your first 180 days [*plan can change this to 90 days if the enrollee is coming from another health plan*] in the plan if:
* you’re taking a drug that’s not on our *List of Covered Drugs*
* health plan rules don’t let you get the amount ordered by your doctor, **or**
* the drug requires prior approval (PA) by <plan name>.

[*Plan may insert the following if it elects not to include the new member kit with the welcome mailing:* You’ll 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* [*Plan may delete and replace with the following sentence if it elects not to send the Provider and Pharmacy Directory to enrollees:* Instructions for getting more information about the providers and pharmacies in our network]
* [*Plan may insert the following if it elects to include the Member ID Card with the welcome mailing:* Member ID Card]
* [*Plan may insert the following if it elects to include the Member Handbook with the welcome mailing:* *Member Handbook* (*Evidence of Coverage*)]
* [*Plan may insert the following if it elects to include the Summary of Benefits with the welcome mailing:* Summary of Benefits]

[*If 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 <URL>. 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 won’t have to pay a plan premium, deductible, or copays when getting health 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’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 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.]

[*If applicable, insert:*

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

*Information instructing member in simple terms how to choose a primary care provider/site, how to get services, which services don’t 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?**

Call Illinois Client Enrollment Services to join another Medicare-Medicaid Plan. Contact information is in the List of Resources at the end of this notice.

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

**Yes.** You may leave <plan name> or choose a new Medicare-Medicaid Plan **at any time during the year** by calling Illinois Client Enrollment Services. Contact information is in the List of Resources at the end of this notice.

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.

**How will I get my Medicaid services if I leave <plan name>?**

[**If MLTSS** **is not** **an option** in the member’s county, plans must include the following language: If you leave the Medicare-Medicaid Plan, you will get your Medicaid services through fee-for-service.]

[**If MLTSS** **is an option** in the member’s county, plans must include the following language: If you leave the Medicare-Medicaid Plan, you will either get your Medicaid services through fee-for-service or be required to enroll in a HealthChoice Illinois Managed Long-Term Services and Supports (MLTSS) health plan to get your Medicaid services.

If you are not in a nursing facility or enrolled in a Home and Community-Based Services (HCBS) Waiver, you will get your Medicaid services through fee-for-service. You can use any provider that accepts Medicaid and new patients.

If you are in a nursing facility or are enrolled in an HCBS Waiver, you will be required to enroll in a HealthChoice Illinois MLTSS health plan to get your Medicaid services.

To choose a HealthChoice Illinois MLTSS health plan, you can call Illinois Client Enrollment Services. Contact information is in the List of Resources at the end of this notice. Tell them you want to leave <plan name> and join an MLTSS health plan.]

[All plans with a CY 2025 MLTSS contract must include the following language **if MLTSS is an option** in the member’s county: If you don’t pick a HealthChoice Illinois MLTSS health plan, you will be assigned to our company’s HealthChoice IllinoisMLTSS health plan.]

[All plans without a CY 2025 MLTSS contract must include the following language **if MLTSS** **is an option** in the member’s county: If you don’t pick a HealthChoice Illinois MLTSS health plan, you will be assigned to a different company’s HealthChoice Illinois MLTSS health plan. <Plan name> does not have a HealthChoice Illinois MLTSS health plan.]

After you are enrolled in a HealthChoice Illinois MLTSS health plan, you will have 90 days to switch to another HealthChoice Illinois MLTSS health plan.

You will get a new Member ID Card, a new Member Handbook, and [*insert if applicable:* information about how to access the ***or***a new] Provider and Pharmacy Directory from your HealthChoice Illinois MLTSS health plan.

**How will I get my Medicare services 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.

**What if I have questions?**

You can get answers and help. Contact information is in the List of Resources at the end of this notice. The calls and the help are free.

[*Plan should include the following paragraph if it intends to conduct early HRS or HRAs:*

**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.]

[*Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.

**List of Resources**

**The calls and the help are free!**

| For questions about: | Contact: |
| --- | --- |
| **This notice or plan coverage** | <**Plan name**> |
|  | Call: <toll-free phone number> |
|  | TTY users call: <toll-free TTY number> |
|  | <days and hours of operation> |
|  | Online: <URL> |
| **Enrollment** | **Illinois Client Enrollment Services** |
|  | Call: 1-877-912-8880 |
|  | TTY users call: 1-866-565-8576 |
|  | Monday – Friday, 8:00 a.m. – 6:00 p.m. |
|  | Online: [EnrollHFS.Illinois.gov](https://enrollhfs.illinois.gov/) |
| **Medicaid** | **Illinois Health Benefits Hotline** |
|  | Call: 1-800-226-0768 |
|  | TTY users call: 1-877-204-1012 |
|  | Monday – Friday, 8:00 a.m. – 4:30 p.m.  Online: [Illinois.gov/HFS](https://www.illinois.gov/HFS/Pages/default.aspx) |
| **Medicare** | **Medicare** |
|  | Call: 1-800-MEDICARE (1-800-633-4227) |
|  | TTY users call: 1-877-486-2048 |
|  | 24 hours a day, 7 days a week |
|  | Online: [Medicare.gov](https://www.medicare.gov/) |
| **Other enrollment choices:** | **Senior Health Insurance Program (SHIP)** |
|  | Call: 1-800-252-8966 |
|  | TTY users call: 1-888-206-1327 |
|  | Monday – Friday, 8:30 a.m. – 5:00 p.m. |
|  | E-mail: [AGING.SHIP@illinois.gov](mailto:AGING.SHIP@illinois.gov)  Online: [Illinois.gov/Aging/SHIP](https://www2.illinois.gov/aging/ship/Pages/default.aspx) |
| **Coverage decisions, appeals, or complaints:** | **Illinois Home Care Ombudsman** |
|  | Call: 1-800-252-8966 |
|  | TTY users call: 1-888-206-1327 |
|  | Monday – Friday, 8:30 a.m. – 5:00 p.m. |
|  | E-mail: [Aging.HCOProgram@illinois.gov](mailto:Aging.HCOProgram@illinois.gov)  Online: [Illinois.gov/HCOP](https://www2.illinois.gov/aging/programs/LTCOmbudsman/Pages/The-Home-Care-Ombudsman-Program.aspx) |