**KEEP THIS NOTICE FOR YOUR RECORDS!**

<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Participant # >

<RxID>

<RxGroup>

<RxBin>

<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.**

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

<Name>:

Medicare and New York Medicaid told us that you will be in <plan name> beginning <effective date>. [Insert plan’s legal or marketing name] is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide and coordinate both your Medicare and Medicaid benefits through the Fully Integrated Duals Advantage (FIDA) Demonstration.

A representative of <plan name> will reach out to you to schedule a time for a nurse to visit you to help you 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>.

<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 receiving your FIDA services. There is no monthly premium, no deductible, and no copayment. 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 wheelchairs;
* 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 receive].

You may begin using <plan name> network providers and pharmacies for all of your 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. As you get used to our plan, you can keep seeing the providers (including doctors and home care providers) you go to now for 90 days after <effective date>*.* You can also keep taking medicines (prescription drugs) you currently take for at least 90 days even if: 1) <plan name> does not cover them; 2) <plan name> rules do not let you get the amount ordered by your doctor; or 3) <plan name> 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 receive 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 that 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)
* Provider and Pharmacy Directory
* [*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 Member ID Card and Member Handbook separately from the welcome mailing, the plan must insert the following*: Before <enrollment effective date>, we will send you [a Participant ID card] [and] [a Participant Handbook (Evidence of Coverage)].]

**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> ID card from us.]**

How much do I have to pay for services?

You do not have to pay a plan premium, deductible or copayments 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 copayment 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: <TTY number>) 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: <TTY number>).]

**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>?**

Yes. You may leave <plan name> or choose a new FIDA Plan **at any time** 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.

**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 [www.icannys.org](http://www.icannys.org).

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

Thank you,

<Plan Name>

[Insert plan’s legal or marketing name] is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. [This disclaimer must be placed in both English and all non-English languages that meet the Medicare and state thresholds for translation. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]

You can ask for this notice in other formats, such as Braille or large print. Call [insert Participant Service phone and TTY/TDD numbers, and hours of operation].

The State of New York has created a Participant Ombudsman Program to provide Participants free, confidential assistance on any services offered by <plan name>. The Participant Ombudsman may be reached toll-free at 1-844-614-8800 or online at [www.icannys.org](http://www.icannys.org).

**List of Resources**

|  |  |  |
| --- | --- | --- |
| **<Plan Name>**  For questions about your plan coverage |  | Call: <toll-free number>  TTY users: <TTY number>  <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: [www.nymedicaidchoice.com](http://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: [www.medicare.gov](http://www.medicare.gov) |
| **Independent Consumer Advocacy Network (ICAN)**  For questions about your rights |  | Call: 1-844-614-8800  TTY users: 711  A free interpreter: 1-844-614-8800  Monday-Friday, 8:00 am – 8:00 pm  The call and the help are free.  Online: [www.icannys.org](http://www.icannys.org) |