[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> Member ID: <Member’s Plan ID#>

Beneficiary ID: <Member’s Medicaid ID#>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

Your enrollment in <plan name> has changed.

[Insert one or more of the following, including sufficient detail to describe the specific enrollment change:

You will now get your health care services and prescription drug coverage through <plan name>.

Your <plan name> coverage starts <**start date**> and ends <**end date**>. [Plan should insert information about how to access coverage, etc.]

**or**

You will now get your health care services and prescription drug coverage through <new plan name>.

Your enrollment in your previous plan has been changed to <new plan name>. Your coverage with <new plan name> starts <**date**>. [Plan should insert information on cost sharing and other details the individual will need to ensure past and future coverage is clear.]

**or**

Your <plan name> health care services and prescription drug coverage will start on <date>.

Your coverage in <plan name> will start on <**date**>. This date is earlier than you were originally told. [Plan should include information about coverage and how to get refunded for prescriptions purchased in the period of retroactive coverage.]

**or**

Your <plan name> health care services and prescription drug coverage will start on <date>.

Your coverage in <plan name> will start on <**date**>. This date is later than you were originally told. [Plan should insert information about impact to paid claims.]

**or**

Your <plan name> health care services and prescription drug coverage [insert as appropriate: ended or will end] on <date>.

Your coverage in <plan name> [insert as appropriate: ended **or** will end] on <**date**>. This means you [insert as appropriate: do not **or** will not] have coverage through <plan name> after this date. [Plan should insert appropriate descriptive information, such as impact on paid claims or how to submit claims, as applicable.]

**or**

Your enrollment in <plan name> will end soon.

Your <plan name> health services will end on <**date**>. This means you will not have coverage through <plan name> after this date. [Plan should insert information about impact to any paid claims.]

[Plan should insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the member, as necessary.]]

**What if I have questions?**

* For questions about **this notice,** call <plan name> <Member Services or the term the plan uses> at <toll-free phone and TTY numbers>, <days and hours of operation>. You can also visit <MMP URL>.
* For questions about **your enrollment**, 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 a.m. to 7 p.m.
* For questions about **Medicare** or help with your Medicare options, 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 or visit the Medicare home page at [www.medicare.gov](http://www.medicare.gov/).
* For general questions about your **Medicare enrollment options**, you can also call the Michigan Medicare 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 a.m. to 5 p.m. The call is free.

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

[*Plans must increase the font size and may 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 <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.