Instructions to Health Plans

* [Plans may include the ANOC in the 2025 Member Handbook (Evidence of Coverage) or provide it to members separately.]
* [Before use, plans must upload in HPMS only (1) a standalone ANOC and (2) a standalone EOC (Member Handbook). Plans should work with their marketing reviewers to withdraw any duplicate material submitted in error. Plans must enter Actual Mail Dates (AMDs) for ANOCs in accordance with CMS requirements as detailed in the “Update AMD/Beneficiary Link/Function” section of the Marketing Review Users Guide in HPMS. Note that plans must enter AMD information for ANOC mailings only for mailings to current members. Plans should not enter ANOC AMD information for October 1, November 1, or December 1 effective enrollment dates or for January 1 effective enrollment dates for any new members.]
* [Plans should follow the instructions in the State-specific Marketing Guidance regarding use of the standardized plan type (Medicare-Medicaid Plan) following the plan name. Plans should not use ICO when referring to themselves. Plans should use health plan or MI Health Link where appropriate.]
* [Plans may change references of “member” to “enrollee” as they choose.]
* [Plans should replace the reference to “Member Services” with the term the plan uses.]
* [Plans should refer members to the 2025 Member Handbook using the appropriate chapter number and section. For example, “refer to Chapter 9, Section A.” An instruction [plans may insert reference, as applicable] is listed next to each cross reference.]
* [Where the template instructs inclusion of a phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:
* Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Member Handbook, insert: **This section is continued on the next page**).
* Ensure plan-customized text is in plain language and complies with reading level requirements established in the three-way contract.
* Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.
* Spell out an acronym or abbreviation before its first use in a document or on a page (for example, Long term services and supports (LTSS) or low income subsidy (LIS)).
* Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.
* Avoid separating a heading or subheading from the text that follows when paginating the model.
* Use universal symbols or commonly understood pictorials.
* Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.
* Consider using regionally appropriate terms or common dialects in translated models.
* Include instructions and navigational aids in translated models in the translated language rather than in English.]

**<Plan name> <plan type> offered by <sponsor name>**

*Annual Notice of Changes* for 2025

[**Optional:** insert member name]

[**Optional:** insert member address]

Introduction

[If there are any changes to the plan for 2025, insert: You are currently enrolled as a member of <plan name>. Next year, there will be changes to the plan’s [insert as applicable: benefits, coverage, and rules]. This [insert as applicable: section **or** Annual Notice of Changes] tells you about the changes and where to find more information about them. To get more information about costs, benefits, or rules please review the Member Handbook, which is located on our website at <URL>. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.]

[If there are no changes whatsoever for 2025 (e.g., no changes to benefits, coverage, rules, networks), insert: You are currently enrolled as a member of <plan name>. Next year, there are no changes to the plan’s benefits, [and] coverage [insert if applicable: and rules]. However, you should still read this [insert as applicable: section **or** Annual Notice of Changes] to learn about your coverage choices. To get more information about costs, benefits, or rules please review the Member Handbook, which is located on our website at <URL>. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.]

[*Any plan that does not include a particular section (e.g., Section C, Section F) deletes the section, orders all remaining sections and subsections sequentially, and updates the Table of Contents accordingly.* Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

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# Disclaimers

* [Plans must include all applicable disclaimers as required in the State-specific Marketing Guidance.]
* [Plans may insert additional disclaimers or state-required statements, including state-required disclaimer language, here.]

# Reviewing your Medicare and Michigan Medicaid coverage for next year

It is important to review your coverage now to make sure it will still meet your needs next year. If it does not meet your needs, you may be able to leave the plan. Refer to section G2 for more information.

If you leave our plan, you will still be in the Medicare and Michigan Medicaid programs as long as you are eligible.

* You will have a choice about how to get your Medicare benefits (refer to section <section letter>).
* If you do not want to enroll in a different Medicare-Medicaid Plan after you leave <plan name>, you will return to getting your Medicare and Michigan Medicaid services separately.

| B1. Additional resources  * [Plans must increase the font size and may use bold font to emphasize the following information.] [Plans may include either the current multi-language insert or provide a Notice of Availability. Plans that choose to use the current multi-language insert per 42 CFR §§ 422.2267(e)(31) and (e)(33) should include: We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at <phone number>. Someone that speaks <language> can help you. This is a free service. [This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state.]   *OR*  *Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31) and 423.2267(e)(33), plans may choose to provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in Michigan and must be provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.*]   * [*Plans must increase the font size and may use bold font to emphasize the following information.*]You can also 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. * [Plans that meet the 5% alternative language or Medicaid required language threshold insert: This document is available for free in [*insert* languages that meet the threshold *as described the “Standards for required materials and content section” of the Marketing Guidance for Michigan Medicare-Medicaid Plans*.]] * [Plans also must describe in simple terms:   + how they will request a member’s preferred language other than English and/or alternate format,   + *how they will keep the member’s information as a standing request for future mailings and communications so the member does not need to make a separate request each time, and*   + *how a member can change a standing request for preferred language and/or format.*]  B2. Information about <plan name>  * <Plan name> is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees. * Coverage under <plan name> is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement. * <Plan name> is offered by [insert sponsor name]. When this *Annual Notice of Changes* says “we,” “us,” or “our,” it means [insert sponsor name]. When it says “the plan” or “our plan,” it means <plan name>.  B3. Important things to do:  * **Check if there are any changes to our benefits that may affect you.** * Are there any changes that affect the services you use? * It is important to review benefit changes to make sure they will work for you next year. * Refer to sections <section number> [plans may insert reference, as applicable] and <section number> [plans may insert reference, as applicable] for information about benefit changes for our plan. * **Check if there are any changes to our prescription drug coverage that may affect you.**    + Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? Will there be any changes such as prior authorization, step therapy, or quantity limits?   + It is important to review the changes to make sure our drug coverage will work for you next year.   + Refer to section <section number> [plans may insert reference, as applicable] for information about changes to our drug coverage. * **Check if your providers and pharmacies will be in our network next year.**   + Are your doctors, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use?   + Refer to section <section number> [plans may insert reference, as applicable] for information about our *Provider and Pharmacy Directory*. * **Think about your overall costs in the plan.** * [Insert if applicable: How much will you spend out-of-pocket for the services and prescription drugs you use regularly?]   + How do the total costs compare to other coverage options? * **Think about whether you are happy with our plan.** |
| --- |

| **If you decide to stay with <2025 plan name>:** | **If you decide to change plans:** |
| --- | --- |
| If you want to stay with us next year, it’s easy – you don’t need to do anything. If you don’t make a change, you will automatically stay enrolled in our plan. | [Plans should revise this paragraph as necessary] If you decide other coverage will better meet your needs, you may be able to switch plans (refer to section G2 for more information). If you enroll in a new plan, your new coverage will begin on the first day of the following month. Refer to section <section number>, section <section letter> [plans may insert additional reference, as applicable] to learn more about your choices. |

# Changes to the plan’s name

[Plans that are not changing the plan name, delete this section. Plans with an anticipated name change at a time other than January 1 may modify the date below as necessary.]

On January 1, 2025, our plan name will change from <2024 plan name> to <2025 plan name>.

[Insert language to inform members whether they will get new Member ID Cards and how, as well as how the name change will affect any other member communication.]

# Changes to the network providers and pharmacies

[Plans with no Part D copays may delete the following paragraph] Amounts you pay for your prescription drugs may depend on which pharmacy you use. Our plan has a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. [Insert if applicable: Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.]

[Plans with no changes to network providers and pharmacies insert: We have not made any changes to our network of providers and pharmacies for next year.

However, it is important that you know that we may make changes to our network during the year. If your provider does leave the plan, you have certain rights and protections. For more information, refer to Chapter 3 of your Member Handbook [plans may insert reference, as applicable].]

[Plans with changes to provider and/or pharmacy networks, as described in the Provider and Pharmacy Directory Requirements in the State-specific Marketing Guidance, insert: Our[insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has **or** have] changed for 2025.

**Please review the 2025 Provider and Pharmacy Directory** to find out if your providers or pharmacy are in our network. An updated Provider and Pharmacy Directory is located on our website at <MMP URL>. You may also call Member Services at <toll-free phone and TTY numbers> for updated provider information or to ask us to mail you a Provider and Pharmacy Directory.

It is important that you know that we may also make changes to our network during the year. If your provider does leave the plan, you have certain rights and protections. For more information, refer to Chapter 3 of your Member Handbook [plans may insert reference, as applicable].]

# Changes to benefits for next year

## E1. Changes to benefits for medical services

[If there are no changes in benefits, replace the rest of the section with: There are no changes to your benefits for health care services. Our benefits will be exactly the same in 2025 as they are in 2024.]

We are changing our coverage for certain health care services next year. The table below describes these changes.

[The table must include:

* all new benefits that will be added or 2024 benefits that will end for 2025;
* new or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2025.]

|  | **2024 (this year)** | **2025 (next year)** |
| --- | --- | --- |
| [**Insert benefit name**] | [For benefits that were not covered in 2024, insert:  [insert benefit name] is **not** covered.] | [For benefits that will not be covered in 2025, insert:  [insert benefit name] is **not** covered.] |
| [**Insert benefit name**] | [Insert 2024 coverage, using format described above.] | [Insert 2025 coverage, using format described above.] |

## E2. Changes to prescription drug coverage

**Changes to our *Drug List***

[Plans thatdid not includea List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: You will get a 2025 List of Covered Drugs in a separate mailing.]

[Plans thatdid not includea List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: An updated List of Covered Drugs is located on our website at <MMP URL>. You may also call Member Services at <toll-free phone and TTY numbers> for updated drug information or to ask us to mail you a List of Covered Drugs.]

[Plans thatincludeda List of Covered Drugs in the envelope, insert: We sent you a copy of our 2025 List of Covered Drugs in this envelope.] The *List of Covered Drugs* is also called the “*Drug List*.”

[Plans with no changes to covered drugs, tier assignment, or restrictions may replace the rest of this section with: We have not made any changes to our Drug List at this time for next year. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or the state. We update our online Drug List at least monthly to provide the most up to date list of drugs. If we make a change that will affect a drug you are taking, we will send you a notice about the change. Refer to the 2025 Drug List for more information.]

We made changes to our *Drug List*, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the *Drug List*to **make sure your drugs will be covered next year** and to find out if there will be any restrictions.

Most of the changes in the *Drug List* are new for the beginning of each year. However, we might make other changes are allowed by Medicare and/or the state that will affect you during the plan year. We update our online *Drug List* at least monthly to provide the most up to date list of drugs. If we make a change that will affect a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage, we encourage you to:

* Work with your doctor (or other prescriber) to find a different drug that we cover.
  + You can call Member Services at <toll-free phone and TTY numbers> [insert if applicable:or contact your Care Coordinator] to ask for a list of covered drugs that treat the same condition.
  + This list can help your provider find a covered drug that might work for you.
* [Plans should include the following language if they have an advance transition process for current members:]Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug.
  + You can ask for an exception before next year and we will give you an answer within 72 hours after we get your request (or your prescriber’s supporting statement).
  + To learn what you must do to ask for an exception, refer to Chapter 9 of the *2025 Member Handbook* [plans may insert reference, as applicable] or call Member Services at <toll-free phone and TTY numbers>.
  + If you need help asking for an exception, you can contact Member Services [insert if applicable: or your Care Coordinator]. Refer to Chapter 2 [plans may insert reference, as applicable] and Chapter 3 [plans may insert reference, as applicable] of the *Member Handbook* to learn more about how to contact your Care Coordinator.
* [Plans should include the following language if all current members will not be transitioned in advance for the following year:]Ask the plan to cover a temporary supply of the drug.
  + In some situations, we will cover a **temporary** supply of the drug during the first [must be at least 90] days of the calendar year.
  + This temporary supply will be for up to [insert supply limit (must be the number of days in plan’s one-month supply)] days. (To learn more about when you can get a temporary supply and how to ask for one, refer to Chapter 5 of the *Member Handbook* [plans may insert reference, as applicable].)
  + When you get a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

[Plans must include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]

[Plans must include language to explain whether current formulary exceptions will still be covered next year or a new one needs to be submitted.]

[Plans that previously implemented the option to immediately replace brand name drugs with their new generic equivalents and plan to maintain this option for 2025, please insert the following language, which provides notice of the expansion of this option for 2025: We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version [insert if applicable: on the same or a lower cost-sharing tier] and with the same or fewer rules as the brand name drug it replaces. Also, when adding a new generic drug, we may also decide to keep the brand name drug on our Drug List, but immediately [insert if applicable: move it to a different cost-sharing tier or] add new rules [insert if applicable: or both].

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month’s supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your Member Handbook. The Food and Drug Administration (FDA) also provides consumer information on drugs. Refer to the FDA website: [www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients](https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients). You may also contact Member Services at the number at the bottom of the page or ask your health care provider, prescriber, or pharmacist for more information.]

[Plans implementing for the first time in 2025 the option to immediately substitute brand name drugs with their new generic equivalents or authorized generics or to immediately substitute biological products with interchangeable biosimilars or unbranded biosimilars, that otherwise meet the requirements, should insert the following: Starting in 2025, we may immediately remove brand name drugs or original biological products on our Drug List if, we replace them with new generics or certain biosimilars versions of the brand name drug or original biological product [insert if applicable: on the same or lower cost-sharing tier and] with the same or fewer rules. Also, when adding a new version, we may decide to keep the brand name drug or original biological product on our Drug List, but immediately [insert if applicable: move it to a different cost-sharing tier or] add new rules [insert if applicable: or both.]

This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month’s supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your Member Handbook. The Food and Drug Administration (FDA) also provides consumer information on drugs. Refer to the FDA website: [www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients](https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients). You may also contact Member Services at the number at the bottom of the page or ask your health care provider, prescriber, or pharmacist for more information.]

**Changes to prescription drug costs**

There are no changes to the amount you pay for prescription drugs in 2025. Read below for more information about your prescription drug coverage.

[Insert if applicable: **We moved some of the drugs on the Drug List to a lower or higher drug tier.** To know if your drugs will be in a different tier, find them in the Drug List.]

The following table shows your costs for drugs in each of our <number of tiers> drug tiers.

[Plans must list all drug tiers in the following table.]

|  | 2024 (this year) | **2025 (next year)** |
| --- | --- | --- |
| **Drugs in Tier <Tier number>**  ([Insert short description of tier (e.g., generic drugs)])  Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | [Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$0 per prescription**.] | [Insert 2025 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$0 per prescription**.] |
| **Drugs in Tier <Tier number>**  ([Insert short description of tier (e.g., generic drugs)])  Cost for a one-month supply of a drug in Tier <Tier number> that is filled at a network pharmacy | [Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$0 per prescription**.] | [Insert 2025 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$0 per prescription**.] |

# Administrative changes

[This section is optional. Plans with administrative changes that impact members (e.g., change in contract or PBP number) may insert this section, include an introductory sentence that explains the general nature of administrative changes, and describe the specific changes in the table below.]

|  | **2024 (this year)** | **2025 (next year)** |
| --- | --- | --- |
| [Insert a description of the administrative process/item that is changing] | [Insert 2024 administrative description] | [Insert 2025 administrative description] |
| [Insert a description of the administrative process/item that is changing] | [Insert 2024 administrative description] | [Insert 2025 administrative description] |

# How to choose a plan

## G1. How to stay in our plan

We hope to keep you as a member next year.

You do not have to do anything to stay in your health plan.If you do not sign up for a different Medicare-Medicaid Plan, change to a Medicare Advantage Plan, or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2025.

## G2. How to change plans

You can end your membership at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

These are the four ways people usually end membership in our plan:

|  |  |
| --- | --- |
| **1. You can change to:**  **A different Medicare-Medicaid Plan** | **Here is what to do:**  Call Michigan ENROLLS toll-free at 1-800-975-7630. Persons with hearing and speech disabilities may call the TTY number at 1-888-263-5897. Office hours are Monday through Friday, 8 AM to 7 PM.  Your coverage in our plan will end the last day of the month after you tell us you want to leave. |
| **2. You can change to:**  **A Medicare health plan (such as a Medicare Advantage Plan or Program of All-inclusive Care for the Elderly (PACE))** | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.  If you need help or more information:   * Call the State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare Assistance Program (MMAP).   You will automatically be disenrolled from <plan name> when your new plan’s coverage begins. |
| **3. You can change to:**  **Original Medicare with a separate Medicare prescription drug plan** | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.  If you need help or more information:   * Call the State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare Assistance Program (MMAP).   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |
| **4. You can change to:**  **Original Medicare without a separate Medicare prescription drug plan**  **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don’t want to join.  You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call MMAP at 1-800-803-7174. | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.  If you need help or more information:   * Call the State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare Assistance Program (MMAP).   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |

# How to get help

## H1. Getting help from <plan name>

Questions? We’re here to help. Please contact [insert if applicable: your Care Coordinator or call] Member Services at <toll-free phone and TTY numbers>. We are available for phone calls <days and hours of operation>. Calls to these numbers are free.

**Your *2025* *Member Handbook***

The *2025* *Member Handbook* is the legal, detailed description of your plan benefits. It has details about next year's benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs.

[If the ANOC is sent or provided separately from the Member Handbook, include the following: The 2025 Member Handbook will be available by October 15.] [Insert if applicable: You can also review the <attached **or** enclosed **or** separately mailed> Member Handbook to find out if other benefit changes affect you.] An up-to-date copy of the *2025 Member Handbook* is available on our website at <MMP URL>. You may also call Member Services at <toll-free phone and TTY numbers> to ask us to mail you a *2025 Member Handbook*.

**Our website**

You can also visit our website at <MMP URL>. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our *Drug List* (*List of Covered Drugs*).

## H2. Getting help from Michigan ENROLLS

For questions about your enrollment, call **Michigan ENROLLS** toll-free **at 1-800-975-7630**. Persons with hearing and speech disabilities may call the TTYnumber at 1-888-263-5897. Office hours are Monday through Friday, 8 AM to 7 PM.

## H3. Getting help from the MI Health Link Ombudsman Program

The MI Health Link Ombudsman Program can help you if you are having a problem with <plan name>. The ombudsman’s services are free.

* The MI Health Link Ombudsman Program works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do.

The MI Health Link Ombudsman Program makes sure you have information related to your rights and protections and how you can get your concerns resolved.

The MI Health Link Ombudsman Program is not connected with us or with any insurance company or health plan. Call 1-888-746-MHLO (1-888-746-6456). Office hours are Monday through Friday, 8 AM to 5 PM EST.

## H4. Getting help from the State Health Insurance Assistance Program (SHIP)

You can also call the State Health Insurance Assistance Program (SHIP). The SHIP has trained counselors in every state, and services are free. In Michigan, the SHIP is called the Michigan Medicare Assistance Program (MMAP). MMAP counselors can help you understand your Medicare-Medicaid Plan choices and answer questions about switching plans. MMAP is not connected with us or with any insurance company or health plan.

Call MMAP at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM.

## H5. Getting help from Medicare

To get information directly from Medicare, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Medicare’s Website**

You can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)). If you choose to disenroll from your Medicare-Medicaid Plan and enroll in a Medicare Advantage plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare Medicare Advantage plans.

You can find information about Medicare Advantage plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, refer to [www.medicare.gov](http://www.medicare.gov) and click on “Find plans.”)

***Medicare & You* *2025***

You can read the *Medicare & You 2025* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare.

If you don’t have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf](https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf)) or by calling 1‑800‑MEDICARE (1‑800‑633‑4227), 24 hours a day, 7 days a week. TTY users should call 1‑877‑486‑2048.

## H6. Getting help from Michigan Medicaid

Call the Beneficiary Help Line at 1-800-642-3195. Persons with hearing and speech disabilities may call the TTY number at 1-866-501-5656. Office hours are Monday through Friday, 8 AM to 7 PM.

[Plans may insert similar sections for the QIO or additional resources that might be available.]