<Date>

<Name>

<Address>

<City>, <State> <ZIP>

<Recipient ID#>

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

Your enrollment in <old plan name> has been changed to <new plan name>. Your coverage with <new plan name> starts <**date**>. [Plan should insert information on cost sharing information 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: don’t **or** won’t] 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 won’t 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 beneficiary as necessary.]

**What if I have questions?**

If you have questions, call <plan name> <Member Services or the term the plan uses> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>.

If you have questions about your enrollment, 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. The office hours are Monday through Friday 8 AM to 7 PM.

If you have questions about Medicare or need help with your Medicare options, call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit the [Medicare home page](https://www.medicare.gov/) (<https://www.medicare.gov>). TTY users should call 1-877-486-2048.

If you have general questions about your Medicare enrollment options, you can also call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174. They are open Monday through Friday 8 AM to 5 PM. The call is free.

<Plan name> is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

[*The next sentence following disclaimer must be in English, Arabic, Spanish, and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.*]You can speak with someone about getting this information in other languages. Call <toll-free number>. The call is free.

You can also get this information in other languages and formats, like large print, Braille, and audio CD.