<Date>

<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’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>.

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>.

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 [ended or will end] on <date>.

This means you [don’t **or** won’t] have coverage through <plan name> after this date. [Plan should insert appropriate descriptive information as applicable, such as impact on paid claims or how to submit claims.]

**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. [Insert information about impact to any paid claims.]

[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?**

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.

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

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*https://www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY/TDD 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/TDD number> |
|  | <days and hours of operation> |
|  | Online: <website> |
| **Enrollment** | **Illinois Client Enrollment Services** |
|  | Call: 1-877-912-8880 |
|  | TTY users call: 1-866-565-8576 |
|  | Monday – Friday, 8:00 a.m. – 7:00 p.m. |
|  | Online: [EnrollHFS.Illinois.gov](file:///\\co-adshare\share\Share\OA\OSP\FCHCO\!Financial%20Alignment%20and%20State%20Demos\Marketing\Final%20Marketing%20Materials\State%20Materials\Illinois%20Materials\CY%202019\Draft%20Materials\Notices\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. – 4:45 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  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. |
|  | Email: Aging.HCOProgram@illinois.gov  Online:  <https://www2.illinois.gov/aging/ProtectionAdvocacy/LTCOmbudsman/Pages/The-Home-Care-Ombudsman-Program.aspx> |