Instructions to Health Plans

* [Plans may include the ANOC in the 2021 Member Handbook or provide it to members separately.]
* [Before use and under the appropriate, State-specific material code(s), 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 are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to [*www.hhs.gov/civil-rights/for-individuals/section-1557*](http://www.hhs.gov/civil-rights/for-individuals/section-1557).]
* [Plans may modify the language in the ANOC, as applicable, to address Medical Assistance (Medicaid) benefits and cost sharing for its dual eligible population.]
* [Plans should follow the instructions in the Medicare Communications and Marketing Guidelines and the State’s specific Marketing Guidance regarding use of the standardized plan type (HMO SNP) following the plan name.]
* [Plans may change references to “member,” “customer,” or “beneficiary” to whatever term they prefer.]
* [Plans should replace the reference to “Member Services” with the term the plan uses.]
* [As applicable, plans may use either Primary Care Provider or Primary Care Clinic consistently throughout the document. Plans may spell out the term each time it is used or spell out the term the first time it is used in the document along with the associated acronym, PCP or PCC, and use the associated acronym alone throughout the rest of the document.]
* [Plans may use either prior authorization or service authorization consistently throughout the document.]
* [Where the template uses “medical care,” “medical services,” or “health care services,” plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable.]
* [Plans should insert the Material ID on the first page.]
* [Plan includes American Indian Language insert if plan does not include in its language block/non-discrimination notice.]
* [Plans should refer members to the 2021 Member Handbook using the appropriate chapter number. For example, “see Chapter 9.” 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 and may state the call is free.]
* [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 member reading level requirements.
* Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple 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.
* Consider producing translated models in large print.]

**<Plan name> [insert plan type] offered by [insert sponsor name]**

*Annual Notice of Changes* for 2021

[Optional**:** insert member name]

[Optional: insert member address]

Introduction

[If there are any changes to the plan for 2021, insert: You are currently enrolled as a member of <plan name>. Next year, there will be some changes to the plan’s [insert as applicable: benefits, coverage, rules, [and] costs]. This [insert as applicable: section **or** Annual Notice of Changes] tells you about the changes and where to find more information about them. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook, which will be available at a later date.]

[If there are no changes whatsoever for 2021 (e.g., no changes to benefits, coverage, rules, costs, networks, etc.), insert: You are currently enrolled as a member of <plan name>. Next year, there are no changes to the plan’s benefits, coverage, [and] rules [insert if applicable: and costs]. However, you should still read this [insert as applicable: section **or** Annual Notice of Changes] to learn about your coverage choices. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook, which will be available at a later date.]

[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 Medicare Communications and Marketing Guidelines and State-specific Marketing Guidance.]
* [Plans may insert additional disclaimers or state-required statements, including state-required disclaimer language, here.]

# Reviewing your Medicare and Medical Assistance (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. See section G2 for more information.

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

* You will have a choice about how to get your Medicare benefits (go to Section G, How to choose a plan, to see your options).
* If you choose to leave our plan, you will be automatically enrolled in our plan’s Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county.
  + You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan’s Minnesota Senior Health Options (MSHO) enrollment.
  + If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county.

Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

|  |
| --- |
| B1. Additional resources  * ATTENTION: If you speak [insert language of the disclaimer], language assistance services, free of charge, are available to you. Call <plan name> Member Services at the number at the bottom of this page. The call is free. [This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation. If the plan doesn’t meet either the Medicare or state thresholds for translation of written materials, the above disclaimer should not be included.] * You can get this [insert as applicable: section **or** Annual Notice of Changes] for free in other formats, such as large print, braille, or audio. Call <plan name> Member Services at the number at the bottom of this page. The call is free. * To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Member Services at the number at the bottom of this page.  B2. Information about <plan name>  * <Plan’s legal or marketing name> is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in <plan’s legal or marketing name> depends on contract renewal. * 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** [insert if applicable:**and costs**] **that may affect you.** * Are there any changes that affect the services you use? * It is important to review benefit [insert if applicable: and cost] changes to make sure they will work for you next year. * Look in sections <section letter> [plans may insert reference, as applicable]and <section letter> [plans may insert reference, as applicable]for information about benefit [insert if applicable: and cost] 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 [insert if applicable:cost-sharing]tier? Can you continue to use the same pharmacies? * It is important to review the changes to make sure our drug coverage will work for you next year. * Look in section <section letter> [plans may insert reference, as applicable] for information about changes to our drug coverage. * [*All plans with any Part D cost sharing insert:* Your drug costs may have risen since last year. * Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. * To get additional information on drug prices, visit [www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage](https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage) (Click the "dashboards” link in the middle of the Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information.) * Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.] * **Check to see if your providers and pharmacies will be in our network next year.** * Are your doctors, including specialists you see regularly, in our network? What about your pharmacy? What about the hospitals or other providers you use? * Look in section <section letter> [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 <2021 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. | If you decide other coverage will better meet your needs, you may be able to switch plans (see section G2 for more information). If you enroll in a new plan, you will get a notice of when your new coverage will begin. Look in 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, 2021, our plan name will change from <2020 plan name> to <2021 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 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, see Chapter 3 of your Member Handbook [plans may insert reference, as applicable].]

[**Plans with changes** to provider and/or pharmacy networks, as described in Chapter 4 of the Medicare Managed Care Manual, Chapter 5 of the Medicare Prescription Drug Benefit Manual, and the Provider and Pharmacy Directories Requirements subsection in the Introduction to the State’s specific Marketing Guidance, insert: Our[insert if applicable: provider] [and] [insert if applicable: pharmacy] network[s] [insert as applicable: has or have] changed for 2021.

We strongly encourage you to **review our current Provider and Pharmacy Directory** to see if your providers or pharmacy are still in our network. An updated Provider and Pharmacy Directory is located on our website at <Internet address>. You may also call Member Services at the number at the bottom of this page 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, see Chapter 3 of your Member Handbook [plans may insert reference, as applicable].]

# Changes to benefits [insert if applicable: and costs] for next year

## E1. Changes to benefits [insert if applicable: and costs] for medical services

Please note that the *Annual Notice of Changes* only tells you about changes to your Medicare benefits and costs.

[If there are no changes in benefits or in cost sharing, replace the rest of the section with: There are no changes to your benefits [insert if applicable: or amounts you pay] for medical services. Our benefits [insert if applicable: and what you pay for these covered medical services] will be exactly the same in 2021 as they are in 2020.]

We are changing our coverage for certain medical services [insert if applicable: and what you pay for these covered medical services] next year. The following table describes these changes.

[The table must include:

* all new benefits that will be added or 2020 benefits that will end for 2021
* new or changing limitations or restrictions, including prior authorizations, on benefits for 2021; and
* all changes in cost sharing for 2021 for covered medical services, including any changes to service category out-of-pocket maximums.]

|  | **2020 (this year)** | **2021 (next year)** |
| --- | --- | --- |
| **[Insert benefit name]** | [For benefits that were not covered in 2020, insert:  [insert benefit name] is **not** covered.]  [For benefits with a copayment/copay, insert:  You pay a **$<2020 copayment/copay amount>** <copayment/copay> [insert language as needed to accurately describe the benefit, e.g., “per office visit”].] | [For benefits that will not be covered in 2021, insert:  [insert benefit name] is **not** covered.]  [For benefits with a copayment/copay, insert:  You pay a **$<2021 copayment/copay amount>** <copayment/copay> [insert language as needed to accurately describe the benefit, e.g., “per office visit”].] |
| **[Insert benefit name]** | [Insert 2020 cost or coverage, using format described above.] | [Insert 2021 cost or coverage, using format described above.] |

## E2. Changes to prescription drug coverage

Changes to our Drug List

The *List of Covered Drugs* is also called the “Drug List.”

[Plans that did not include a List of Covered Drugs in the envelope, insert: You will get a 2021 List of Covered Drugs (Drug List) in a separate mailing.]

[Plans that did not include a List of Covered Drugs in the envelope and will not mail it separately unless requested, insert: An updatedList of Covered Drugs (Drug List) is located on our website at <web address>. You may also call Member Services at the number at the bottom of this page for updated drug information or to ask us to mail you a Drug List.]

[Plans that included a List of Covered Drugs in the envelope, insert: We sent you a copy of our 2021 List of Covered Drugs (Drug List) in this envelope.]

[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 for next year. The drugs included on our Drug List will be the same in 2021 as in 2020. 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. See the 2021 Drug List for more information.]

[*Plans that offer indication-based formulary design must include*: If we cover a drug only for some medical conditions, it is clearly identified on our Drug List and in Medicare Plan Finder along with the specific medical conditions that are covered.]

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 see if there will be any restrictions.

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 the number at the bottom of this page [insert if applicable: or contact your care coordinator] to ask for a list of covered drugs that treat the same condition. [Plans should replace the term “care coordinator” with the term they use.]
* 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/physician/health care provider> (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, see Chapter 9 of the *2021 Member Handbook* [plans may insert reference, as applicable] or call Member Services at the number at the bottom of this page.
* If you need help asking for an exception, you can contact Member Services [insert if applicable: or your care coordinator]. See 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 replace the term “care coordinator” with the term they use.]
* [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, see 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/physician/health care provider> 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 may include additional information about processes for transitioning current enrollees to formulary drugs when your formulary changes relative to the previous plan year.]

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

[Only plans with two payment stages (i.e., those charging LIS cost-shares in the initial coverage stage), include the following information in this section of the ANOC. Plans with one payment stage do not include the information in this section.]

[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2021. Read below for more information about your prescription drug coverage.]

There are two payment stages for your Medicare Part D prescription drug coverage under <2021 plan name>. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

| **Stage 1**  **Initial Coverage Stage** | **Stage 2**  Catastrophic Coverage Stage |
| --- | --- |
| During this stage, the plan pays part of the costs of your drugs, and you pay your share. Your share is called the <copayment/copay>.  You begin this stage when you fill your first prescription of the year. | During this stage, the plan pays all of the costs of your drugs through December 31, 2021.  You begin this stage when you have paid a certain amount of out-of-pocket costs. |

The Initial Coverage Stage ends when your total out-of-pocket costs for prescription drugs reaches $6,550. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. See Chapter 6 of the *Member Handbook* [plans may insert reference, as applicable] for more information on how much you will pay for prescription drugs.

## E3. Stage 1: “Initial Coverage Stage”

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the <copayment/copay>. The <copayment/copay> depends on the cost-sharing tier level of the drug. You will pay a <copayment/copay> each time you fill a prescription. If your covered drug costs less than the <copayment/copay>, you will pay the lower price.

[Insert if applicable: **We moved some of the drugs on the Drug List to a lower or higher drug cost-sharing tier level.** If your drugs move from one tier level to another, this could affect your <copayment/copay>. To see if your drugs will be in a different cost-sharing tier level, look them up in the Drug List.]

Our plan’s Drug List will have only one tier of drugs in 2021. However, what you pay for a drug on the Drug List depends on whether the drug is a generic or brand drug. These amounts apply **only**during the time when you are in the Initial Coverage Stage.

[Plans must list all drug copay tier levels in the following table.]

|  | **2020 (this year)** | **2021 (next year)** |
| --- | --- | --- |
| **Drugs in Tier 1 – Generic**  ([Insert short description of 2021 tier (e.g., generic drugs)])  Cost for a one-month supply of a drug in Tier <Tier number - Drug type> that is filled at a network pharmacy | [Insert 2020 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/1.30/$3.60 **per prescription**.] | [Insert 2021 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/$1.30/$3.70 **per prescription**.] |
| **Drugs in Tier 1 – Brand**  ([Insert short description of 2021 tier (e.g., brand drugs)])  Cost for a one-month supply of a drug in Tier <Tier number - Drug type> that is filled at a network pharmacy | [Insert 2020 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/$3.90/$8.95 **per prescription**.] | [Insert 2021 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/$4.00/$9.20 **per prescription**.] |

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$**6,550. At that point the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. See Chapter 6 of the *Member Handbook* [plans may insert reference, as applicable] for more information about how much you will pay for prescription drugs.

## E4. Stage 2: “Catastrophic Coverage Stage”

When you reach the out-of-pocket limit $6,550 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. You will pay nothing while you are in this stage.

Changes to prescription drug costs

[Only plans with one payment stage (i.e., those with no cost-sharing for all Part D drugs), include the following information in this section of the ANOC. Plans with two payment stages do not include the information in this section.]

[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2021. 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 cost-sharing tier level.** [Insert if applicable: If your drugs move from one tier level to another tier level, this could affect your <copayment/copay>.] To see if your drugs will be in a different cost-sharing tier level, look them up in the Drug List.]

The following table shows your costs for drugs in each of our drug cost-sharing tier levels.

[Plans must list all drug copay tier levels in the following table.]

|  | 2020 (this year) | **2021 (next year)** |
| --- | --- | --- |
| **Drugs in Tier 1 – Generic**  [Insert short description of 2021 tier (e.g., generic drugs)]  Cost for a one-month supply of a drug in Tier <Tier number - Drug type> that is filled at a network pharmacy | [Insert 2020 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/$1.30/$3.60 **per prescription**.] | [Insert 2021 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/$1.30/$3.70 **per prescription**.] |
| **Drugs in Tier 1 – Brand**  [Insert short description of 2021 tier (e.g., brand drugs)]  Cost for a one-month supply of a drug in Tier <Tier number - Drug type> that is filled at a network pharmacy | [Insert 2020 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/$3.90/$8.95 **per prescription**.] | [Insert 2021 cost sharing: Your <copayment/copay> for a one-month ([insert number of days in a one-month supply]-day) supply is **$**0/$4.00/$9.20 **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 following table.]

|  | **2020 (this year)** | **2021 (next year)** |
| --- | --- | --- |
| [Insert a description of the administrative process/item that is changing] | [Insert 2020 administrative description] | [Insert 2021 administrative description] |
| [Insert a description of the administrative process/item that is changing] | [Insert 2020 administrative description] | [Insert 2021 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 our health plan. If you want to stay in our plan, you will automatically stay enrolled.

## G2. How to change plans

Most people with Medicare can end their membership during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

* January to March
* April to June
* July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

* The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in <plan name> will end on December 31 and your membership in the new plan will start on January 1. [*If the plan is being crosswalked, replace previous sentence with:* If you don’t choose another plan by December 7, your enrollment in <crosswalked plan name> will start on January 1.]
* The **Medicare Advantage Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan will start the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, such as when:

* You have moved out of our service area,
* Your eligibility for Medicaid or Extra Help has changed, or
* You are getting care in a nursing home or a long-term care hospital.

Eligibility for enrollment periods can vary. Contact <plan name> at the number at the bottom of this page if you are unsure which enrollment periods you may use.

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

|  |  |
| --- | --- |
| **1. You can change to:**  **A different Minnesota Senior Health Options (MSHO) Plan** | **Here is what to do:**  Enroll in the new Minnesota Senior Health Options (MSHO) Plan by calling the State Health Insurance Assistance Program (SHIP) at 1-800-333-2433 (TTY users call 711). In Minnesota, the SHIP is called the Senior LinkAge Line®.  You will automatically be disenrolled from <plan name> when your new plan’s coverage begins. |
| **2. You can change to:**  **A Medicare health plan, such as a Medicare Advantage Plan or a Program of All-inclusive Care for the Elderly (PACE) and** [insert as applicable: **another choice for Medical Assistance (Medicaid)** or **stay with the current Medical Assistance (Medicaid) services**] | **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 1-800-333-2433 (TTY users call 711). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free.   You will automatically be disenrolled from <plan name> when your new plan’s coverage begins.  If you choose to leave our plan, you will be automatically enrolled in our plan’s Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan’s MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services. |
| **3. You can change to:**  **Original Medicare with a separate Medicare prescription drug plan and** [insert as applicable: **another choice for Medical Assistance** **(Medicaid)** or **stay with the current Medical Assistance (Medicaid) services**] | **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 1-800-333-2433 (TTY users call 711). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free.   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins.  If you choose to leave our plan, you will be automatically enrolled in our plan’s Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan’s MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services. |
| **4. You can change to:**  **Original Medicare without a separate Medicare prescription drug plan and** [insert as applicable: **another choice for Medical Assistance (Medicaid)** or **stay with the current Medical Assistance (Medicaid) services**]  **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 the Senior LinkAge® at 1-800-333-2433 (TTY users call 711). | **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 1-800-333-2433 (TTY users call 711). In Minnesota, the SHIP is called the Senior LinkAge Line*®*. These calls are free.   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins.  If you choose to leave our plan, you will be automatically enrolled in our plan’s Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan’s MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services. |

# How to get help

## H1. Getting help from <plan name>

Questions? We’re here to help. Please call Member Services at the number at the bottom of this page.

Your *2021 Member Handbook*

The *2021* *Member Handbook* is the legal, detailed description of your plan benefits. It has details about next year's benefits [insert if applicable: and costs]. 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 2021 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 see if other benefit [insert if applicable: or cost] changes affect you.] An up-to-date copy of the *2021 Member Handbook* will be available on our website at <Internet address>. You may also call Member Services at the number at the bottom of this page to ask us to mail you a current *Member Handbook*.

**Our website**

You can also visit our website at <Internet address>. 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 the Ombudsman for Public Managed Health Care Programs

The Ombudsman for Public Managed Health Care Programs is an ombudsman program that can help you if you are having a problem with <plan name>. The ombudsman’s services are free. The Ombudsman for Public Managed Health Care Programs:

* 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.
* Makes sure you have information related to your rights and protections and how you can get your concerns resolved.
* Is not connected with us or with any insurance company or health plan. The phone number for the Ombudsman for Public Managed Health Care Programs is 1-651-431-2660 (Twin Cities metro area); 1-800-657-3729 (outside the Twin Cities metro area). TTY users call 711.

## H3. Getting help from the State Health Insurance Assistance Program (SHIP)

You can also call the State Health Insurance Assistance Program (SHIP). The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. The services are free. In Minnesota, the SHIP is called the Senior LinkAge Line®*.* Senior LinkAge Line® counselors can help you understand your MSHO Plan choices and answer questions about switching plans. The Senior LinkAge Line® is not connected with us or with any insurance company or health plan. The phone number for the Senior LinkAge Line® is 1-800-333-2433 (TTY users call 711). These calls are free.

## H4. 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 MSHO 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, go to [www.medicare.gov](http://www.medicare.gov) and click on “Find plans.”)

*Medicare & You 2021*

You can read the *Medicare & You 2021* 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/medicare-and-you](http://www.medicare.gov/medicare-and-you)) 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.

## H5. Getting help from Medical Assistance (Medicaid)

Minnesota’s office of Medical Assistance (Medicaid) is the Department of Human Services. Call 1-800-657-3739 (outside Twin Cities metro area) or 1-651-431-2670 (Twin Cities metro area). TTY users should call 1-800-627-3429 or 711.