**Instructions to Health Plan**

* [Plan may include the ANOC in the 2024 Member Handbook (Evidence of Coverage) or provide it to members separately.]
* [Before use, the plan must upload in HPMS only (1) a standalone ANOC and (2) standalone EOC (Member Handbook). Plan should work with their marketing reviewers to withdraw any duplicate material submitted in error. Plan 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 the plan must enter AMD information for ANOC mailings only for mailings to current members. The plan 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.]
* [Plan may modify the language in the ANOC, as applicable, to address Medicaid benefits and cost sharing for its dual eligible population.]
* [Plan should follow the instructions in the State-specific Marketing Guidance regarding use of the standardized plan type (Medicare-Medicaid Plan) following the plan name.]
* [Plan may change references to “member,” “customer,” or “beneficiary” to whatever term they prefer.]
* [Where the template uses “medical care,” “medical services,” or “health care services,” plan may revise and/or add references to long-term services and supports (LTSS) and/or home and community-based services as applicable.]
* [Plan should refer members to the 2024 Member Handbook using the appropriate chapter number, section, and/or page number. For example, “refer to Chapter 9, Section A, page 1.” An instruction [plan may insert reference, as applicable] is listed next to each cross reference.]
* [Where the template instructs inclusion of a phone number, plan must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation.]
* [Wherever possible, the plan is 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.
* Consider producing translated models in large print.]

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

***Annual Notice of Changes* for 2024**

[Optional: insert member name]

[Optional: insert member address]

Introduction

[If there are any changes to the plan for 2024, 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, 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. To get more information about costs, benefits, or rules please review the Member Handbook, which is located on our website at [insert 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 2024 (e.g., no changes to benefits, coverage, rules, costs, networks), 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. To get more information about costs, benefits, or rules please review the Member Handbook, which is located on our website at [insert 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.* Plan 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

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

# Reviewing your Medicare and 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 Medicaid programs as long as you are eligible.

* You will have a choice about how to get your Medicare benefits (refer to page <page number>).
* You will be enrolled in Rhode Island Medicaid Fee for Service (FFS) for your Medicaid services. Your Medicaid services include most long-term services and supports (LTSS) (if you are eligible) and behavioral health care. [Plan may add the specific Medicaid services it provides.]
* You will get a new Member ID Card. You will also get a [insert: new Provider and Pharmacy Directory **or** information about the providers and pharmacies in our network]. [Plan may insert the following if it sends the Member Handbook separately from the welcome mailing: We will send you a Member Handbook (Evidence of Coverage).] [If plan elects not to send the Member Handbook to enrollees, insert: An up-to-date copy of the Member Handbook (Evidence of Coverage) is always available on our website at <web address>. You may also call Member Services at <toll-free number> to ask us to mail you a Member Handbook.]

| Resources |
| --- |
| B1. Additional resources  * ATTENTION: If you speak [insert language of the disclaimer], language assistance services, free of charge, are available to you. Call [insert Member Services toll-free phone and TTY numbers, and days and hours of operation]. The call is free. [This disclaimer must be included in Spanish and any other non-English languages that meet the Medicare and/or state thresholds for translation.] * 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. Please call Member Services at <toll-free number>, <days and hours of operation>. TTY users should call <TTY number>. The call is free. * [Plan also must simply describe:   + 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’s legal or marketing name> is a health plan that contracts with both Medicare and Rhode Island 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 <sponsor name>. When this *Annual Notice of Changes* says “we,” “us,” or “our,” it means <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> [plan may insert reference, as applicable] and <section letter> [plan 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> [plan may insert reference, as applicable] for information about changes to our drug coverage. * [*Plan 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](http://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 if your providers and pharmacies will be in our network next year.** * Are your providers, including your specialists, in our network? What about your pharmacy? What about the hospitals or other providers you use? * Look in section <section letter> [plan 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 <plan name>:** | **If you decide to leave <plan name>:** |
| --- | --- |
| 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. | [The plan should revise this paragraph as necessary] If you decide other coverage will better meet your needs, you may be able to leave our plan (refer to section G2 for more information). If you leave our plan, your new coverage will begin on the first day of the following month. Look in section <section letter>, page <page number> to learn more about your choices. |

# Changes to the plan’s name

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

On January 1, 2024, our plan name will change from <2023 plan name> to <2024 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

[Plan 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 [plan may insert reference, as applicable].]

[Plan 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 2024.

**Please review the 2024 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 <web address>. You may also call Member Services at <toll-free number> 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 [plan 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 health care services

[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 health care services. Our benefits [insert if applicable: and what you pay for these covered health care services] will be exactly the same in 2024 as they are in 2023.]

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

[The table must include:

* all new benefits that will be added or 2023 benefits that will end for 2024;
* new or changing limitations or restrictions, including prior authorizations (PA), on benefits for 2024; and
* all changes in cost sharing for 2024 for covered health care services, including any changes to service category out-of-pocket maximums.]

|  | **2023 (this year)** | **2024 (next year)** |
| --- | --- | --- |
| **[Insert benefit name]** | [For benefits that were not covered in 2023, insert:  [insert benefit name] is **not** covered.]  [For benefits with a copay insert:  You pay a **$<2023 copay amount>** copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].] | [For benefits that will not be covered in 2024, insert:  [insert benefit name] is **not** covered.]  [For benefits with a copay insert:  You pay a **$<2024 copay amount>** copay [insert language as needed to accurately describe the benefit, e.g., “per office visit”].] |
| **[Insert benefit name]** | [Insert 2023 cost or coverage, using format described above.] | [Insert 2024 cost or coverage, using format described above.] |

## E2. Changes to prescription drug coverage

**Changes to our Drug List**

[Plan thatdid not includea List of Covered Drugs in the envelope, insert: You will get a 2024 List of Covered Drugs in a separate mailing.]

[Plan 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 <web address>. You may also call Member Services at <toll-free number> for updated drug information or to ask us to mail you a List of Covered Drugs.]

[Plan that includeda List of Covered Drugs in the envelope, insert: We sent you a copy of our 2024 List of Covered Drugs in this envelope.] The *List of Covered Drugs* is also called the “Drug List.”

[Plan 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. However, we are allowed to make changes to the Drug List from time to time throughout the year, with approval from Medicare and/or Rhode Island Medicaid. Refer to the 2024 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.

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

* Work with your provider (or other prescriber) to find a different drug that we cover.
  + You can call Member Services at <toll-free number> [insert if applicable:or contact your care manager] 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.
* [Plan should include the following language if they have an advance transition process for current members:]Work with your 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, refer to Chapter 9 of the *2024 Member Handbook* [plan may insert reference, as applicable] or call Member Services at <toll-free number>.
* If you need help asking for an exception, you can contact Member Services [insert if applicable: or your care manager]. Refer to Chapter 2 [plan may insert reference, as applicable] and Chapter 3 [plan may insert reference, as applicable] of the *Member Handbook* to learn more about how to contact your care manager.
* [Plan 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 your *Member Handbook* [plan may insert reference, as applicable].)
* When you get a temporary supply of a drug, you should talk with your 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.

[Plan 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.]

**Changes to prescription drug costs [option for plan with two drug payment stages]**

[Plan with two payment stages (i.e., a plan charging LIS cost-shares in the initial coverage stage) should include the following information in the ANOC.]

[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. Read below for more information about your prescription drug coverage.]

There are two payment stages for your Medicare Part D prescription drug coverage under <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 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, 2024.  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 [insert as applicable:**$<initial coverage limit amount>**or**$<TrOOP amount>**]. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. Refer to Chapter 6 of your *Member* Handbook [plan may insert reference, as applicable] for more information about 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 copay. The copay depends on what cost-sharing tier the drug is in and where you get it. You will pay a copay each time you fill a prescription. If your covered drug costs less than the 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 tier.** If your drugs move from tier to tier, this could affect your copay. To find out if your drugs will be in a different tier, look them up in the Drug List.]

The table below shows your costs for drugs in each of our <number of tiers> drug tiers. These amounts apply **only**during the time when you are in the Initial Coverage Stage.

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

|  | **2023 (this year)** | **2024 (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 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription**.] | [Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX>** **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 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX>** **per prescription**.] | [Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX>** **per prescription**.] |

The Initial Coverage Stage ends when your total out-of-pocket costs reach [insert as applicable: **$<initial coverage limit amount>** or **$<TrOOP amount>**]. At that point the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year. Refer to Chapter 6 of your *Member Handbook* [plan 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 [insert as applicable:**$<initial coverage limit>** or **$<TrOOP amount>**] for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year.

* [Plan that does not reduce the copays for Medicaid-covered drugs in the catastrophic coverage stage should insert the following language: When you are in the Catastrophic Coverage Stage, you will continue to make copays for your Medicaid-covered drugs.]
* [Plan that does not reduce the copays for Medicaid-covered drugs in the catastrophic coverage stage should insert the following language: To locate more information about which of your prescriptions are covered by Rhode Island Medicaid versus Medicare, refer to the List of Covered Drugs, [plan may insert reference, as applicable].]

**Changes to prescription drug costs** [option for plan with a single payment stage]

[Plan with one payment stage (i.e., a plan with no cost-sharing for all Part D drugs) should include the following information.]

[If there are no changes in prescription drug costs, insert: There are no changes to the amount you pay for prescription drugs in 2024. 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**. [Insert if applicable: If your drugs move from tier to tier, this could affect your copay.] To find out if your drugs will be in a different tier, look them up in the Drug List.]

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

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

|  | **2023 (this year)** | **2024 (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 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription**.] | [Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> 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 2023 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription**.] | [Insert 2024 cost sharing: Your copay for a one-month ([insert number of days in a one-month supply]-day) supply is **$<XX> per prescription**.] |

# Administrative changes

[This section is optional. Plan 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.]

|  | **2023 (this year)** | **2024 (next year)** |
| --- | --- | --- |
| [Insert a description of the administrative process/item that is changing] | [Insert 2023 administrative description] | [Insert 2024 administrative description] |
| [Insert a description of the administrative process/item that is changing] | [Insert 2023 administrative description] | [Insert 2024 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 change to a Medicare Advantage Plan, change to Original Medicare, enroll in a Medicare Part D plan, or disenroll from <plan name> and enroll in Rhode Island Medicaid Fee for Service (FFS) for your Medicaid benefits, you will automatically stay enrolled as a Member of our plan for 2024.

## G2. How to change plans

[If the plan’s state continues to implement a continuous Special Enrollment Period for dual eligible members (duals SEP) insert:You can end your membership at any time during the year by disenrolling from <plan name> and enrolling in another Medicare Advantage Plan, moving to Original Medicare, or enrolling in a Medicare Part D plan and enrolling in Rhode Island Medicaid Fee for Service (FFS) for your Medicaid benefits.]

[If the plan’s state implements the dual-eligible individual and other LIS-eligible individual quarterly SEP effective 2019, insert: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.
* 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, when:

* Medicare or Rhode Island Medicaid has enrolled you into a Medicare-Medicaid Plan,
* Your eligibility for Rhode Island Medicaid or Extra Help has changed,
* You recently moved into, currently are getting care in, or just moved out of a nursing home or a long-term care hospital, **or**
* You have moved out of our service area.]

## G3. Leaving <plan name>

As long as you’re still eligible for Medicare and Rhode Island Medicaid, you can leave <plan name> and keep getting your Medicare and Medicaid benefits.

You will get your Medicaid benefits directly from doctors and other providers. This is called Rhode Island Medicaid Fee for Service (FFS).

There are three ways you can get your Medicare benefits:

|  |  |
| --- | --- |
| **1. 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)** | **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 to enroll in the new Medicare-only health plan.  If you need help or more information:   * Call the Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444. TTY users should call 711. They will refer you to a State Health Insurance Assistance Program (SHIP) counselor.   You will automatically be disenrolled from <plan name> when your new plan’s coverage begins. |
| **2. 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 Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444. TTY users should call 711. They will refer you to a State Health Insurance Assistance Program (SHIP) counselor.   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |
| **3. 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 the Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444. TTY users should call 711. They will refer you to a State Health Insurance Assistance Program (SHIP) counselor. | **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 Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444. TTY users should call 711. They will refer you to a State Health Insurance Assistance Program (SHIP) counselor.   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 call Member Services at <toll-free number> (TTY only, call <TTY number>). We are available for phone calls <days and hours of operation>.

**Your *2024 Member Handbook***

The *2024* *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 2024 *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 [insert if applicable: or cost] changes affect you.] An up-to-date copy of the *2024 Member Handbook* is available on our website at <web address>. You may also call Member Services at <toll-free number> to ask us to mail you a *2024* *Member Handbook*.

**Our website**

You can also visit our website at <web 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 state enrollment broker

[Plan should insert information about the enrollment broker, including a brief description on what kind of help the enrollment broker can provide.] You can call the Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469, Monday-Friday, 8:00 am – 6:00 pm. TTY users should call 711.

## H3. Getting help from the RIPIN Healthcare Advocate

The RIPIN Healthcare Advocate is an ombudsman program that can help you if you are having a problem with <plan name>. The ombudsman’s services are free.

* The RIPIN Healthcare Advocate is an ombudsman program that 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 RIPIN Healthcare Advocate makes sure you have information related to your rights and protections and how you can get your concerns resolved.
* The RIPIN Healthcare Advocate is not connected with us or with any insurance company or health plan. The phone number for the RIPIN Healthcare Advocate is 1-855-747-3224 (TTY 711).

## H4. Getting help from the State Health Insurance Assistance Program (SHIP) and the Medicare-Medicaid Enrollment Supports (MME) Program

You can also call the State Health Insurance Assistance Program (SHIP) to speak with a SHIP counselor about Medicare. In Rhode Island, the SHIP is provided by the Office of Healthy Aging (OHA). The SHIP has trained counselors in every state, and services are free. To speak with a SHIP counselor, call 1-888-884-8721 (TTY 711).

The Medicare-Medicaid Enrollment Supports Program (MME) gives free one-on-one health insurance counseling to people with Medicare and Medicaid. In Rhode Island, the MME is provided by The POINT. To speak with an MME counselor, call 1-401-462-4444 (TTY 711) or call 2-1-1.

For more information, refer to Chapter 2 of your *Member Handbook* [plan may insert reference, as applicable].

## 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 2024***

You can readthe *Medicare & You 2024* 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 Rhode Island Medicaid

For questions about the help you get from Medicaid, call Rhode Island Medicaid at the DHS Call Center at 1-855-697-4347.

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