Medicare Managed Care Manual

Chapter 2 - Medicare Advantage Enrollment and Disenrollment

Updated: August 19, 2011
(Revised November 16, 2011, August 7, 2012 ~~& August 30, 2013~~& August 30, 2013)

This guidance update is effective for contract year 2012. All enrollments with an effective date on or after January 1, 2012, must be processed in accordance with the revised guidance requirements, including new model enrollment forms and notices, as appropriate. Organizations may, at their option, implement any aspect of this guidance prior to the required implementation date. Please note that all clarifications to Special Election Periods (SEPs) are effective upon release of this new guidance, with the exception of the SEP to Enroll in an MA Plan with a Plan Performance Rating of Five Stars, which is effective December 8, 2011.

The revisions made on August 30, 2013~~7, 2012~~, are effective for contract year ~~2013~~2014. All enrollments with an effective date on or after January 1, ~~2013~~2014, must be processed in accordance with the changes made in this revision as appropriate. Organizations may, at their option, implement any of these changes, including new model notices, prior to the required implementation date.

It is expected that Organizations will assure that all requirements outlined in this chapter regarding communications made with beneficiaries/members, including the use of the model notices, are also in compliance with the standards and guidelines as established in the Medicare Marketing Guidelines.

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For Chapter 2, a reference to an "MA plan" includes MA local plans, MA Regional Preferred Provider Organization (PPO) plans and MA-PD plans (including special needs plans), unless otherwise specified.

The instructions provided in this chapter apply to MA plans, including MA-PD plans. Instructions for enrollment (and disenrollment) in a Prescription Drug Plan (PDP) or an 1876 cost plan are provided in a separate guidance.

10 - Definitions

The following definitions relate to topics addressed in this guidance.

Application Date – For paper enrollment forms and other enrollment request mechanisms, the application date is the date the enrollment request is initially received by the organization as defined below. Plans must use this date in the appropriate field when submitting enrollment transactions to CMS. A summary of application dates for CMS enrollment transactions is provided in Appendix 3 of this guidance.

- For requests sent by mail, the application date is the date the application is received by the organization (postmark is irrelevant).
- For requests received by fax, the application date is the date the fax is received on the organization's fax machine.
- For requests submitted to sales agents, including brokers, the application date is the date the agent/broker receives (accepts) the enrollment request and not the date the organization receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the organization, is considered receipt by the plan, thus all CMS required timeframes for enrollment processing begin on this date.
- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and have been recorded.
- For requests made via the Medicare.gov Online Enrollment Center (OEC), the application date is the date CMS "stamps" on the enrollment request at the time the individual completed the OEC process. This is true regardless of when an organization ultimately retrieves or downloads the request.
- For ~~*internet*~~ *electronic* enrollment requests ~~made directly to the organization's website~~, the application date is the date the *applicant completes the* request ~~is completed~~ through the organization's *electronic enrollment* ~~website~~ process. This is true regardless of when an organization ultimately retrieves or downloads the request.
- For all enrollments into employer group or union sponsored plans using the SEP EGHP, the application date used on the transaction submitted to CMS will always be the 1st of the month prior to the effective date of enrollment for all mechanisms at all times. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the organization receives the request. For example, if a valid group enrollment mechanism file is received by the organization on January 24th for enrollments effective February 1st, the receipt date for the provision of required notices is January 24th and the application date submitted on the enrollment transactions is January 1st.

- For auto- or facilitated enrollment, as described in §40.1.5, the application date is the first day of the month prior to the effective date of the auto/facilitated enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the auto- or facilitated enrollment in CMS systems.

Authorized Representative/Legal Representative – An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions.

Cancellation of Enrollment Request - An action initiated by the beneficiary to cancel an enrollment request. To be valid, the cancellation request must be received by the organization before the enrollment effective date. An enrollment request that has been appropriately cancelled is considered not to have been used and the election remains available for use within the time frame of the applicable election period.

Completed Election - An enrollment request is considered complete when:

1. The form/request is signed by the beneficiary or legal representative (refer to §40.2.1 for a discussion of who is considered to be a legal representative), or the enrollment request mechanism is completed;

2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the Medicare Advantage organization (see below for definition of "evidence of Medicare Part A and Part B coverage");

3. All necessary elements on the form are completed (for enrollments, see Appendix 2 for a list of elements that must be completed) or when the enrollment request mechanism is completed as CMS directs, and, when applicable;

4. Certification of a legal representative's authority to make the enrollment request is obtained by attestation (refer to §40.2.1).

5. For Special Needs Plans (SNP), verification of SNP eligibility, as described in §20.11. Chronic condition SNPs (C-SNP) that utilize a CMS-approved pre-enrollment qualification assessment tool will consider the enrollment request to be complete upon receipt of the completed tool.

If an individual is involuntarily disenrolled for failure to pay premiums, to re-enroll in that plan, or enroll into another, he or she would need to request enrollment during a valid enrollment period. In addition, for enrollments into an MA-only (non MA-PD) plan, an MA organization may also choose to wait for the individual's payment of the plan premium, including any premiums due the MA organization for a prior enrollment before considering an enrollment "complete."

Continuation Area/Continuation of Enrollment Option - A continuation area is an additional CMS-approved area outside the MA local plan's service area within which the MA organization furnishes or arranges for furnishing of services to the MA local plan's continuation of enrollment members. MA organizations have the option of establishing continuation areas for MA local plans.

Conversions - For individuals who are enrolled in a health plan offered by the MA organization the month immediately before the month of their entitlement to Medicare Parts A and B, their enrollment in an MA plan offered by the same organization is referred to as a "conversion" from non-Medicare status to MA enrollee status. In order for the individual's enrollment with the organization as an MA enrollee to take effect upon becoming eligible for Medicare, conversions must take place during the individual's Initial Coverage Election Period (ICEP).

Denial of Enrollment Request - Occurs when an MA organization determines that an individual is not eligible to make an enrollment request (e.g., the individual is not entitled to Medicare Part A or enrolled in Part B, the individual has ESRD, the individual is not making the enrollment request during an election period, etc.), and therefore determines it should not submit the enrollment request transaction to CMS.

Effective Date of Coverage/Enrollment – The date on which an individual's coverage in an MA plan begins. The MA organization must determine the effective date of enrollment for all enrollment requests. Instructions for determining the correct effective date of coverage are provided in §30.6.

Election - Enrollment in, or voluntary disenrollment from, an MA plan or the traditional Medicare fee-for-service program ("Original Medicare") constitutes an election. (Disenrollment from Original Medicare would occur only when an individual enrolls in an MA plan.) The term "election" is used to describe either an enrollment or voluntary disenrollment. If the term "enrollment" is used alone, however, then the term is used deliberately, i.e., it is being used to describe only an enrollment, and not a disenrollment. The same applies when the term "disenrollment" is used alone, i.e., the term is being used to describe only a disenrollment, and not an enrollment.

Election Period - The time(s) during which an eligible individual may request to enroll in or disenroll from an MA plan. The type of election period determines the effective date of MA coverage as well as the types of enrollment requests allowed. There are several types of election periods, all of which are defined under §30.

Enrollment Request Mechanism - A method used by individuals to request to enroll in an MA plan. Several model individual enrollment forms are provided in the Exhibits at the end of this guidance. **An individual who is a member of an MA plan and who wishes to elect another MA plan, even if it is in the same MA organization, must complete a new election during a valid enrollment period to enroll in the new MA plan**. However, that individual may use a short enrollment form (refer to Exhibit 3) or a "plan selection" form (refer to Exhibit 3a) to make the election in place of the comprehensive individual enrollment form, or, may complete the election via the Internet, as described in §40.1.2 of this guidance, or by telephone, as described in §40.1.3 of this guidance, if the MA organization offers these options. In addition, MA organizations may want to collaborate with Employer/Union Group Health Plans (EGHPs) to use a single enrollment form (or other CMS approved method, if available) for EGHP members; a model EGHP enrollment form for this purpose is provided in Exhibit 2. Beneficiaries or their

legal representatives must complete an enrollment request mechanism (e.g. enrollment form) to enroll in an MA plan.

Beneficiaries are not required to use a specific form to disenroll from an MA plan; however, a model disenrollment form is provided in Exhibit 10.

Evidence of Entitlement (Medicare Part A and Part B Coverage) - For the purposes of completing an enrollment request, the MA organization must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen). Therefore, the applicant is not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request.

If CMS systems do not show Medicare entitlement, the organization must consider the individual's Medicare ID card as evidence of Medicare entitlement. If CMS systems do not show Medicare entitlement and the individual's Medicare ID card is not available, the organization must consider an SSA award letter that shows the Medicare HICN and effective date of Part A/B as evidence of Medicare entitlement.

Evidence of Permanent Residence - A permanent residence is normally the enrollee's primary residence. An MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills to verify the primary residence. Such records must establish the permanent residence address, and not the mailing address, of the individual.

Full-Benefit Dual Eligible Individual – For purposes of Medicare Prescription Drug benefits (Part D), is a Medicare beneficiary who is determined eligible by the state for medical assistance for full benefits under title XIX of the Social Security Act for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act, or medical assistance under section 1902(a)(10)(C) of the Act (medically needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

"Good Cause" – This term refers to the standards established in § 60.3.4 under which an individual may be reinstated into his/her MA plan when involuntarily disenrolled for failure to pay the plan's premium or the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) premium amount.

Incarceration – This term refers to the status of an individual who is confined to a correctional facility, such as a jail or prison. An individual who is incarcerated is considered to be residing outside of the service area for the purposes of MA plan eligibility, even if the correctional facility is located within the plan service area. Beneficiaries who are in Institutions for Mental Disease (IMDs), such as individuals who are confined to state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, are not considered to be incarcerated as CMS defines the term for the purpose of MA eligibility. These individuals are therefore not excluded from the service area of an MA plan on that basis.

Institutionalized Individual - An individual who resides in an institution:

- Skilled nursing facility (SNF) as defined in §1819 of the Act (Medicare);
- Nursing facility (NF) as defined in §1919 of the Act (Medicaid);

- Intermediate care facility for the mentally retarded (ICF/MR) as defined in §1905(d) of the Act;
- Psychiatric hospital or unit as defined in §1861(f) of the Act;
- Rehabilitation hospital or unit as defined in §1886(d)(1)(B) of the Act;
- Long-term care hospital as defined in §1886(d)(1)(B) of the Act; or
- Hospital which has an agreement under §1883 of the Act (a swing-bed hospital).

Involuntary Disenrollment - Disenrollments made necessary due to the organization's determination that the individual is no longer eligible to remain enrolled in a plan, or when an organization otherwise initiates disenrollment (e.g. failure to pay plan premiums, plan termination). Procedures regarding involuntary disenrollment are found in §§50.2 and 50.3.

Late Enrollment Penalty (LEP) - An amount added to the MA-PD plan premium of an individual who did not obtain creditable prescription drug coverage when s/he was first eligible for Part D or who had a break in creditable prescription drug coverage of at least 63 consecutive days. The LEP is considered a part of the plan premium.

Medicare Advantage Organization (MA organization) - Refer to Chapter 1 (General Provisions) for a definition of an "MA organization."

MA Organization Error - An error or delay in enrollment request processing made under the full control of the MA organization personnel and one that the organization could have avoided.

Medicare Advantage Plan - Refer to Chapter 1 for a definition of "MA plan." Enrollment requests are made at the MA **plan level**, not at the **MA organization level.**

Other Low Income Subsidy (LIS) Eligible Individuals – For purposes of Medicare Part D benefits, individuals who are determined eligible for the Part D low-income subsidy (LIS) who are not full-benefit dual eligible individuals as defined above. This includes individuals deemed eligible for LIS by virtue of having QMB-only, SLMB-only, QI, SSI-only; as well as those who apply and are determined eligible for LIS.

Out-of-Area Members - Members of an MA plan who live outside the service area and who elected the MA plan while residing outside the service area (as allowed in §§20.0, 20.3, 50.2.1, and 50.2.4).

Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) – A premium amount separate from the Part D plan's monthly premium for individuals who have incomes over a certain amount. The Social Security Administration assesses the amount annually based on the enrollee's available tax information. The plan does not collect the Part D-IRMAA as part of its premium. Typically, individuals pay the Part D-IRMAA through their Social Security, Office of Personnel Management or Railroad Retirement Board (RRB) benefit withholding. Some enrollees are directly billed for their Part D-IRMAA through invoices sent by CMS or the RRB. All Part D enrollees who are assessed the Part D-IRMAA are required to pay the IRMAA even if the Part D coverage is provided through an EGHP.

Plan Performance Rating – A CMS-assigned rating, measured in stars from one to five, which indicates an organization's quality and performance based on criteria established by CMS. A star rating of one star indicates poor performance, while a star rating of five stars indicates

exemplary performance. The Plan Performance Overall Rating (or "overall rating") is publicly available on Medicare.gov. CMS assigns the rating in October for the following year based on the organization's most recent quality and performance data.

Receipt of Enrollment Request - MA organizations may receive enrollment requests through various means, as described in §40.1. The MA organization must date as received all enrollment requests as soon as they are initially received. This date will be used to determine the election period in which the request was made, which in turn will determine the effective date of the request. Please refer to the definition of "Application Date" in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.

Reinstatement of Election - An action that may be taken by CMS to correct an erroneous disenrollment from an MA plan. The reinstatement corrects an individual's records by canceling a disenrollment to reflect no gap in enrollment in an MA plan. A reinstatement may result in retroactive disenrollment from another Medicare managed care plan.

Rejection of Enrollment Request - Occurs when CMS has rejected an enrollment request submitted by the MA organization. The rejection could be due to the MA organization incorrectly submitting the transactions, to system error, or to an individual's ineligibility to elect the MA plan.

Special Needs Plan – Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including; institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.

System Error - A "system error" is an unintended error or delay in enrollment request processing that is clearly attributable to a specific Federal government system (e.g., Social Security Administration (SSA) system, Railroad Retirement Board (RRB) system), and is related to Medicare entitlement information or other information required to process an enrollment request.

Voluntary Disenrollment - Disenrollment initiated by a member or his/her authorized representative.

20 - Eligibility for Enrollment in MA Plans

42 CFR 422.50

In general, an individual is eligible to elect an MA plan when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan (see exceptions described under §20.6);

2. The individual has not been medically determined to have ESRD prior to completing the enrollment request (see exceptions described under §20.2);

3. The individual permanently resides in the service area of the MA plan (see exceptions in §20.3 for persons living outside the service area at the time of the enrollment request);

4. The individual or his/her legal representative completes an enrollment request and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Appendix 2 for a list of items required to complete the enrollment form, and §40.2.1 for who may sign enrollment request forms or complete other enrollment request mechanisms);

5. The individual is fully informed of and agrees to abide by the rules of the MA organization that were provided during the enrollment request; and

6. The individual makes a valid enrollment request that is received by the plan during an election period, as described in §30;

7. For a Special Needs Plan (SNP) additional requirements apply as described in §20.11 of this guidance.

8. For an MSA plan, additional requirements apply as described in §20.10 of this guidance.

An MA organization may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in this guidance.

An MA organization must not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in an MA plan and continues to be enrolled in his/her employer/union or spouse's group health benefits plan, then coordination of benefits rules apply.

An MA eligible individual may not be enrolled in more than one MA plan at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described in §§60.1, 60.2 and 60.3.

Individuals enrolled in an MA plan may not concurrently enroll in a PDP except for individuals enrolled in a Medicare MSA plan or individuals enrolled in a PFFS plan that does not offer Medicare prescription drug coverage. An individual enrolled in an MA PFFS plan that does not include a Part D benefit may enroll in a PDP, even if under the same MA contract the organization offers another PFFS plan that includes a Part D benefit.

20.1 - Entitlement to Medicare Parts A and B and Eligibility for Part D

To be eligible to elect an MA plan, an individual must be entitled to Medicare Part A and enrolled in Part B, and must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan. Exceptions for Part B-only "grandfathered" members are outlined in §20.6. Part B only individuals currently enrolled in a plan created under §1833 or §1876 of the Social Security Act (the Act) are not considered to be "grandfathered" individuals, and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an MA plan.

An MA organization has the option to continue to offer Part A-equivalent coverage to Medicare Part B-only "grandfathered" members, as described in §20.6. However, an MA organization may not offer Part A-equivalent coverage to other individuals enrolled only in Medicare Part B (and not entitled to Part A) in order to make them "eligible" for enrollment in an MA plan. Eligibility requirements are met based on Part A entitlement through Medicare and not through the purchase of Part A-equivalent benefits through the MA organization. The MA organization may refer the individual to SSA if the individual wishes to enroll in Medicare Part A in order to be eligible to enroll in the MA plan.

Eligibility for Part D does not exist:

- When the beneficiary is incarcerated.
- When the beneficiary lives abroad.
- For any month prior to the month of notification of the entitlement determination when the entitlement determination for Part A and B is made retroactively.

MA-PDs may not enroll an individual who is not eligible for Part D.

20.2 - End-Stage Renal Disease (ESRD)

Except as provided under exceptions discussed below, an individual is not eligible to elect an MA plan if he/she has been medically determined to have ESRD. ESRD means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. A Medicare beneficiary will be assigned ESRD status by the Medicare ESRD system as a result of the attending physician certifying the ESRD status of the enrollee and completing a CMS Form CMS-2728-U3. For purposes of MA eligibility, an individual's ESRD status begins:

- The date regular dialysis begins, as reported on the Form CMS-2728-U3; or

- The month an individual is admitted to a hospital for a kidney transplant, or for health care services needed before a transplant if the transplant takes place in the same month or within the two following months; or

- The first day of the month dialysis began if the individual trained for self-dialysis.

An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. Such an individual may elect to enroll in a MA plan, if he/she meets other applicable eligibility requirements. If an individual is only eligible for Medicare on the basis of ESRD (i.e., not based

on disability or age), the individual would only be permitted to remain enrolled as an MA enrollee during his or her remaining months of Medicare eligibility.

In addition, an individual who initiated dialysis treatments for ESRD, but subsequently recovered native kidney function and no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. Such an individual may also elect to enroll in a MA plan, if he/she meets other applicable eligibility requirements.

The MA organization is permitted to ask at the time of the enrollment request whether the applicant has ESRD. This question is not considered impermissible health screening since the law does not permit a person with ESRD to elect an MA plan, except as provided in the following paragraphs. If a beneficiary no longer requires regular dialysis or has had a successful transplant, the beneficiary should obtain a note or records from the beneficiary's physician showing that the ESRD status has changed and the beneficiary is in fact eligible to enroll in the MA plan. An MA organization must deny enrollment to any individual medically determined to have ESRD, except as provided in this guidance. CMS systems will reject the enrollment if Medicare records indicate the applicant has ESRD. Follow the instructions in the Plan Communications User Guide to submit valid enrollments for eligible beneficiaries using the "prior commercial indicator" override.

Procedures for identifying whether an individual is medically determined to have ESRD are included in §40.2.4.

20.2.1 - Background on ESRD Entitlement

When an individual files for Medicare based upon ESRD, entitlement can begin:

- The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis);
- The first day of the month dialysis began if the individual trains for self-dialysis;
- The month an individual is admitted to a hospital for a kidney transplant, or for health care services needed before a transplant if the transplant takes place in the same month or within the two following months;
- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before); or
- Prospectively.

The Medicare entitlement date is usually the month an individual receives a transplant or three months after the month the individual begins dialysis (i.e., the first day of the fourth month of dialysis). For example, if an individual begins dialysis in January, Medicare entitlement is effective April 1. Therefore, for these individuals, the initial coverage election period (ICEP) would be the time between when dialysis begins and the Medicare entitlement date - the 3-month waiting period for Medicare entitlement.

There are individuals who are approved to perform self-dialysis. If an individual is approved for self-dialysis, SSA will waive the 3-month waiting period to begin Medicare entitlement. In cases

of self-dialysis, Medicare entitlement is effective the month dialysis begins, rather than the customary 3 months from the month the individual begins dialysis.

EXAMPLE

A Medicare record is established in January for an April 1 entitlement effective date. Since the individual has 3-month waiting period waived, SSA submits a changed record for a January 1 Medicare entitlement effective date.

Medicare pays nothing until the individual files for benefits and Medicare coverage becomes effective.

Individuals sometimes elect a prospective effective date to coordinate with the end of their 30-month coordination period. In the case of an individual in a group health plan**,** the group plan is required to be the primary payer for the first 30 months of Medicare eligibility or entitlement (also known as the 30-month coordination of benefits period), as long as the individual chooses to be enrolled in the group health plan. There is nothing to require an individual to file for Medicare immediately upon starting dialysis. The group health plan is primary during the coordination of benefits period, without regard to the number of individuals employed and irrespective of current employment status.

Since an ICEP generally relates to when an individual becomes entitled to Medicare Part A and B, when possible the group or MA organization should coordinate with the individual so that he/she will not be adversely impacted if he/she has the option to elect an MA plan.

20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD

Please note that a Medigap (supplemental insurance) policy is not considered to be a “health plan” for the purpose of determining whether an individual is eligible for one of the following exceptions. For instructions regarding enrollees with ESRD in employer/union sponsored health plans, see § 20.2.3.

1. Conversions upon ICEP: Individuals who developed ESRD while a member of a health plan offered by an MA organization and who are converting to Medicare Parts A and B, can elect an MA plan in the same organization (within the same State) as their health plan during their ICEP. (“Conversion” is defined in §10 and the time frames for the ICEP are covered in §30.2.) The individuals must meet all other MA eligibility requirements and must fill out an enrollment request form or complete an alternate enrollment request mechanism to join the MA plan.

2. Conversions other than ICEP:

   (a.) If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an MA plan offered by the MA organization, as long as they were enrolled in a health plan offered by the same MA organization the month before their entitlement to Parts A and B, developed ESRD while a member of that health plan, and are still enrolled in that health plan. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who

performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period **after** dialysis begins.

These individuals will be given a special election period. See §30.4.4 for additional instructions.

(b.) Individuals who develop ESRD while enrolled in a health plan (e.g., a commercial or group health plan, or a Medicaid plan) offered by the MA organization are eligible to elect an MA plan offered by that organization. In order to be eligible, there must be no break in coverage between enrollment in the health plan offered by an MA organization, and the start of coverage in the MA plan offered by the same organization.

(c.) Individuals who develop ESRD while enrolled in an employer's self-funded health plan and who were provided access to the MA organization's provider network under arrangement between the employer and the MA organization are eligible to elect an MA plan offered by that MA organization.

3. An individual who elects an MA plan and who is medically determined to first have ESRD after the date on which the enrollment form is signed (or receipt date stamp if no date is on the form, per §40.2), or the enrollment request is made by alternate means provided by CMS, but before the effective date of coverage under the plan is still eligible to elect the plan.

4. An individual who develops ESRD while enrolled in an MA plan may continue to be enrolled in the MA plan.

5. Once enrolled in an MA plan, a person who has ESRD may elect other MA plans in the same MA organization (and during allowable enrollment request periods, as described under §30.). However, the member would not be eligible to elect an MA plan in a different MA organization or a plan in the same MA organization in a different State.

6. An individual with ESRD whose enrollment in an MA plan was terminated on or after December 31, 1998, as a result of a contract termination, non-renewal, or service area reduction can make one enrollment request into a new MA plan. The individual must meet all other MA eligibility requirements, and must enroll during an MA election period described in §30, which includes the SEP associated with that specific termination, non-renewal or service area reduction. Once an individual has exhausted his one election, he/she will not be permitted to join another MA plan, unless his new plan is terminated.

7. Individuals with ESRD may enroll in an SNP that has obtained a waiver to be open for enrollment to individuals with ESRD.

20.2.3 - Optional Employer/Union Group Waiver for ESRD Enrollees

The MA organizations may choose to accept enrollees with ESRD who are enrolling in an MA plan through an employer or union group under the following circumstances:

1. If an employer or union group offers an MA plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, beneficiaries with ESRD

who are otherwise eligible may select this new MA plan option as the employer or union's open enrollment rules allow.

2. If an employer or union group that has been offering a variety of coverage options consolidates its employee/retiree offerings (i.e., it drops one or more plans), current enrollees of the dropped plans may be accepted into an MA plan that is offered by the group.

3. If an employer or union group has contracted locally with an MA organization in more than one geographic area (for example, in two or more states), a beneficiary with ESRD who relocates permanently from one geographic location to another may remain with the MA organization in the local employer or union MA plan.

4. If an employer or union group beneficiary with ESRD ages into Medicare, he/she may enroll in an employer or union sponsored MA plan regardless of prior commercial coverage.

In order to accommodate these four scenarios, we are waiving the regulations at 42 CFR 422.50(a)(2).

The MA organizations that choose to apply this waiver must agree to apply it consistently. Each year, MA organizations may choose whether or not to apply this waiver at the time of their renewal.

20.3 - Place of Permanent Residence

An individual is eligible to elect an MA plan if he/she permanently resides in the service area of the MA plan. Incarcerated individuals are to be considered as residing out of the plan service area, even if the correctional facility is located within the plan service area. A temporary move into the MA plan's service area does not enable the individual to elect the MA plan; the MA organization must deny such an enrollment request.

EXCEPTIONS

- An MA organization may offer a continuation of enrollment option to MA local plan enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the MA organization as a continuation area (refer to §20.8 for more detail on the requirements for the continuation of enrollment option).

- Conversions: Individuals who are enrolled in a health plan of the MA organization and are converting to Medicare Parts A and B can elect an MA local plan offered by the same MA organization during their ICEP even if they reside in the MA organization's continuation area. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.)

- A member who was enrolled in an MA plan covering the area in which the member permanently resides at the time the plan was terminated in that area, may remain enrolled in the MA plan while living outside the plan's new reduced service area if:

    - There is no other MA plan serving the area at that time;

    - The MA organization offers this option; and
    - The member agrees to receive services through providers in the MA plan's service area.

- The MA organization has the option to also allow individuals who are converting to Medicare Parts A and B to elect the MA plan during their ICEP even if they reside outside the service and continuation area. This option may be offered provided that CMS determines that all applicable MA access requirements in 42 CFR 422.112 are met for that individual through the MA plan's established provider network providing services in the MA plan service area, and the organization furnishes the same benefits to the individual as to members who reside in the service area. The organization must apply the policy consistently for all individuals. These members will be known as "out-of-area" members. This option applies both to individual members and to employer or union sponsored group plan members of the MA organization.

Individuals who do not meet the above requirements may not elect the MA plan. The MA organization must deny enrollment to these individuals.

A permanent residence is normally the primary residence of an individual. Proof of permanent residence is normally established by the address of an individual's residence, but an MA organization may request additional information such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment form, the MA organization must contact the individual to confirm that the individual resides in the service area. If there is a dispute over where the individual permanently resides, the MA organization should determine whether, according to the law of the MA organization's State, the person would be considered a resident of that State.

In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

MA organizations have the option to offer "visitor" or "traveler" programs for currently enrolled individuals who are consecutively out of the area for up to 12 months, provided the plan includes the full range of services available to other members (refer to §50.2.1 for more detail on the requirements for the "visitor/traveler" option). Residence in an area designated for a "visitor" or "traveler" program does not make an individual eligible to enroll in an MA plan, but rather applies to already enrolled individuals.

20.3.1 - Mailing Address

As described in §20.3, an individual's eligibility to enroll in an MA plan is in part determined by the individual's permanent residence in the service area of that MA plan. Some individuals may have separate mailing addresses that may or may not be within the geographic plan service area. If an individual requests that mail be sent to an alternate address, such as that of a relative, MA organizations should make every effort to accommodate these requests, and should use this alternate address to provide required notices and other plan mailings, as appropriate. The model MA plan enrollment application forms provided in this guidance include a mechanism to collect

a mailing address. Use of an alternate address does not eliminate or change the requirement of residency for the purposes of MA plan eligibility.

20.4 - Completion of Enrollment Request

An eligible individual or the individual's legal representative (as described in §40.2.1) must complete an enrollment request to enroll in an MA plan, even if that individual is electing an MA plan in the same MA organization in which he/she is currently enrolled**.** Unless otherwise specified by CMS, an eligible individual can elect an MA plan only if he/she completes an enrollment request, provides required information to the MA organization within required time frames, and submits the properly completed enrollment request to the MA organization during a valid enrollment period. Model enrollment forms are included in Exhibits 1, 1b, 1c, 2, and 3.

An individual who is a member of an MA plan, and who wishes to elect another MA plan offered by the same parent organization, must complete a new enrollment request during a valid enrollment period; however, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form or Exhibit 3a for a model plan selection form) in place of the comprehensive individual enrollment form, or may complete the enrollment request via the Internet, as described in §40.1.3 of this chapter, or by telephone, as described in §40.1.4 of this chapter, if the MA organization offers these options.

An MA organization must deny enrollment to any individual who does not properly complete the enrollment form or other mechanism within required time frames. Procedures for completing the enrollment request are provided in §40.2 and Appendix 2. Refer to §10 for a definition of "completed enrollment request."

20.4.1 - Optional Employer/Union Enrollment Request Mechanism

Beginning April 1, 2003, MA organizations that offer MA plans to an employer or union may choose to accept voluntary enrollment requests directly from the employer or union (or its Third Party Administrator (TPA)) without obtaining a paper MA enrollment request form from each individual. The enrollment requests reported to the MA organization by the employer/union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan. This enrollment request mechanism is optional for MA organizations, and may not be required. Therefore, MA organizations may specify the employers and/or unions, if any, from which they will accept this enrollment request format and may choose to accept enrollment and/or voluntary disenrollment requests.

The record of an individual's choice of health plan submitted by the employer or union effectively replaces the paper MA enrollment request form(s). All eligibility, processing and notice requirements, as outlined in this guidance and other references, that pertain to paper enrollment request forms are applicable to this enrollment request mechanism; however, this process does not require the MA organization to obtain a signature. Detailed information and instruction is provided in §40.1.2 for enrollments and §50.1.5 for disenrollments.

Notices of disenrollment, cancellation or termination of coverage not initiated by an enrollee enrollment request (i.e. involuntary disenrollment) are not included in this mechanism. Guidance for these situations is available in §50.1.5.

Additional information regarding employer/union sponsored group health plans can be found in Chapter 9 of this manual.

20.4.2 - Passive Enrollment by CMS

Under Medicare laws and regulations, Medicare beneficiaries must make an enrollment request to enroll in an MA plan and CMS specifies the form and manner in which such enrollment requests are made. CMS has determined that it is legally permissible to provide for enrollment in an MA plan under a passive enrollment request process in specific, limited circumstances generally associated with immediate plan terminations or other situations in which CMS determines that remaining enrolled in the plan would pose potential harm to members.

Passive enrollment is a process by which a beneficiary is informed that he or she will be considered to have made a request to enroll in a new MA plan by taking no action. CMS will determine when passive enrollment is appropriate and will initiate contact through the MA organization's CMS account manager. CMS will provide specific instructions directly to the affected organizations, including instructions on required beneficiary notifications, any required transaction submissions to CMS and information to be provided to affected beneficiaries regarding other enrollment options, if applicable. In evaluating whether such CMS-directed enrollee movements are appropriate, a key factor is the determination as to whether the receiving plan is essentially equivalent to (or better than) the current plan from an overall perspective. For MA-PD plan enrollees, another important goal is to ensure that individuals do not unintentionally lose Part D coverage. The following are some of the key criteria that may be used to determine whether a new plan offering will be considered comparable to or better than the current plan:

- New plan would have a similar or lower out-of-pocket maximum
- New plan would impose a similar or lower hospital cost-sharing amount
- New plan would not impose additional network restrictions
- New plan would retain similar Part B buy-down feature, if applicable
- New plan premium not significantly higher
- New plan's Part D benefit and formulary structure would be equivalent to or of higher value than current plan

20.4.3 - Group Enrollment for Employer or Union Sponsored Plans

CMS is providing a process for group enrollment into an employer/union sponsored MA plan. CMS will allow an employer or union to enroll its retirees using a group enrollment process in which the beneficiaries participate through advance notification and that provides CMS with any information the employer/union has on other insurance coverage for the purposes of coordination of benefits. MA organizations must adhere to the guidelines outlined in §40.1.6, as well as all other program requirements, in developing and implementing this process.

20.5 - Agreeing to Abide by MA Organization Rules

An individual is eligible to elect an MA plan if he/she is fully informed of and agrees to abide by the rules of the MA organization that were provided during the enrollment process (refer to §§40.4, 40.4.1, and 40.4.2 regarding what information must be provided to the individual during the enrollment process). "Fully informed" means that the individual must be provided with the applicable rules of the MA organization, as described in §40.4.1 of this chapter, as well as in the Medicare Marketing Guidelines. The MA organization must deny enrollment to any individual

who does not agree to abide by the rules of the MA organization. Agreement to abide by the rules of the MA organization in this context is made through the completion of the enrollment request.

20.6 - Grandfathering of Members on January 1, 1999

An individual who was enrolled on December 31, 1998, in an HMO with a risk contract under §1876 of the Social Security Act was deemed to be enrolled on January 1, 1999, in an MA plan offered by the same organization if he/she did not choose to disenroll from the organization effective on the latter date. This deemed enrollment applied even if the enrollee was not entitled to Medicare Part A or did not live in an MA plan service area or continuation area. The MA organization was not permitted to disenroll such individuals because they were not entitled to Part A, or did not live in the service or continuation area. However, if these individuals elect to disenroll from the MA organization, they are not eligible to enroll in any MA plan until or unless they meet all MA eligibility requirements.

If enrollment in Medicare Part B ends for an individual, the individual may not continue as a member of the MA plan and must be disenrolled as described in §§50.2.2 and 50.6.

The MA organization must identify all Medicare Part B-only "grandfathered" individuals and inform them of their status annually. This notification may be included as part of the Evidence of Coverage. The notice must inform these individuals that if they disenroll from the MA organization, they cannot elect another MA plan unless they become entitled to Medicare Part A (by enrolling in Medicare Part A at SSA and by paying the appropriate premium to CMS) and remain enrolled in Medicare Part B.

MA organizations may continue to provide Part A-equivalent benefits to Medicare Part B-only grandfathered members. In addition, if an MA organization offers Part A-equivalent coverage as a supplemental benefit in an MA plan, then the MA organization may disenroll a Medicare Part B-only grandfathered member who fails to pay the organization's Part A-equivalent premium, just as any member of the MA organization could be disenrolled for nonpayment of premiums (refer to §50.3.1).

Grandfathered members may enroll in other MA plans in the same MA organization (within the same State). However, if grandfathered members disenroll from the MA organization (i.e., they switch to Original Medicare), they will not be eligible to enroll in any MA plan in any MA organization until or unless they meet all MA eligibility requirements. If the out-of-area grandfathered members disenroll from the MA organization (i.e., they switch to Original Medicare or attempt to enroll in another MA organization), they will only be able to enroll in other MA organizations if they meet all MA eligibility requirements, including, but not limited to, that of living in the service area of the MA plan.

20.7 - Eligibility and the Hospice Benefit

An MA organization must not deny enrollment to any individual who has elected the hospice benefit (except in the case of a Medicare MSA plan; see §20.10 for additional eligibility requirements for Medicare MSA plans). Until the MA organization acknowledges that it has received the completed enrollment request and gives a coverage effective date to the individual (refer to Exhibit 4, Exhibit 4a, and §40), the MA organization must not ask any questions related

to the existence of a terminal illness or election of the hospice benefit. Such questions will be considered impermissible health screening.

The MA organization may not disenroll any member on the basis of the member electing the hospice benefit either before or after becoming a member of the MA plan.

20.8 - Continuation of Enrollment Option for MA Local Plans

With CMS approval, an MA organization may establish continuation areas, separate and apart from an MA local plan's service area. Refer to Chapter 11 (Medicare Advantage Application Procedures and Contract Requirements) regarding CMS approval of continuation areas. As defined in§10, the CMS-approved continuation area is an additional area outside an MA local plan's service area within which the MA organization furnishes or arranges for furnishing of services to the MA plan's members. Members may only choose to continue enrollment with the MA local plan if they have permanently moved from the service area into the continuation area.

As described in Chapter 11, if an MA organization wants to offer a continuation of enrollment option under one or more of the MA local plans it offers, then it must obtain CMS' approval of the continuation area and the marketing materials that describe the continuation of enrollment option. The MA organization must also describe the enrollment option(s) in member materials and make the option available to all members of the MA local plan in question who make a permanent move to the continuation area. An MA organization may require members to give advance notice of their intent to use the continuation of enrollment option. If the MA organization has this requirement, then it must fully describe the required notification process in the CMS-approved marketing materials. In addition, the MA organization must fully explain any continuation option to all potential members of the MA local plan, current members of any other health plan of the MA organization members who reside in the MA local plan service area and/or MA organization continuation area.

If a member who permanently moves from the service area into the continuation area does not choose the continuation of enrollment option when he/she is eligible for the option, then the individual is no longer eligible to be a member of the MA local plan, and the MA organization must initiate the individual's disenrollment. Procedures for continued enrollment are in §60.8 and procedures describing disenrollment for permanent change of residence are described in §50.2.1.

20.9 - Additional Eligibility Requirements for MA Religious Fraternal Benefit (RFB) Plans

An MA RFB plan is a plan that an RFB society may offer only to members of the church, or convention or group of churches with which the society is affiliated. The requirement for membership can be met by any documentation establishing membership issued by the church, or by using the church's records of membership. An individual must also meet all the other requirements to elect an MA plan.

20.10 - Eligibility Requirements for Medicare Medical Savings Account (MSA) Plans

There are additional requirements and limitations for individuals who wish to elect a Medicare Medical Savings Account (MSA) plan. An individual is not eligible to elect a Medicare MSA plan if any one of the following applies:

- The individual will reside in the United States for fewer than 183 calendar days during the year in which the enrollment request is effective;
- The individual is enrolled in a Federal Employees Health Benefits program, or is eligible for health care benefits through the Department of Veterans Affairs or the Department of Defense;
- The individual is dual eligible and is entitled to coverage of Medicare premium and/or cost-sharing under a Medicaid State plan;
- The individual is receiving hospice benefits under the Medicare benefit prior to completing the enrollment request; or
- The individual receives health benefits that cover all or part of the annual Medicare MSA deductible such as through insurance primary to Medicare, supplemental insurance policies not specifically permitted under 42 CFR 422.104, or retirement health benefits.

20.11 - Additional Eligibility Requirements for Enrollment in MA Special Needs Plans

MA Special Needs Plans (SNP) must limit enrollment to individuals who meet specified eligibility requirements in addition to the eligibility requirements in §20 of this chapter. To be eligible for enrollment in a SNP an individual must meet the eligibility requirements for the specific SNP. Refer to Chapter 16-B of the Medicare Managed Care Manual for additional information regarding special needs plan requirements.

Before processing an enrollment into a dual eligible SNP (D-SNP), the SNP must confirm eligibility, including both MA eligibility and Medicaid eligibility. Acceptable proof of Medicaid eligibility can be a current Medicaid card, a letter from the state agency that confirms entitlement to Medical Assistance, or verification through a systems query to a State eligibility data system. The aforementioned documents or State systems verifications are acceptable proof of Medicaid entitlement for beneficiaries residing in the 50 states and the District of Columbia. Only where a state Medicaid agency requires a Social Security number to verify Medicaid status may the SNP enrollment request mechanism include a field for this element. An individual's current eligibility for the Medicare Part D Low Income Subsidy (LIS) or any other Medicaid status flag in CMS systems are not acceptable for initial or ongoing Medicaid eligibility verification for the purposes of determining dual eligible SNP eligibility. For current enrollees, the SNP must verify continuing eligibility (e.g. full or partial dual status, as applicable) at least as often as the state Medicaid agency conducts re-determinations of Medicaid eligibility.

Medicaid subset SNPs may enroll only those dual eligible individuals who meet all applicable MA eligibility requirements and are eligible to enroll in the organization's Medicaid managed care plan, as described in the organization's State contract.

For enrollments into an institutional SNP (I-SNP), the organization must confirm that the individual requires an institutional (skilled nursing facility (SNF), nursing facility (NF), SNF/NF,

intermediate care facility for the mentally retarded (ICF/MR) or inpatient psychiatric facility) level-of-care, and that the need for an institutional level-of-care has lasted 90 days or longer. When an institutional SNP opts to enroll special needs individuals prior to a 90 day length-of-stay, the needs-assessment (pre-approved by CMS) must show that the individual's condition makes it likely that the length-of-stay (or need for an institutional level-of-care) will be at least 90 days.

For enrollments into a chronic condition SNP (C-SNP), the organization must contact the provider or provider's office to confirm that the individual has the qualifying condition. The organization must obtain this information in one of the following two ways:

1) Contact the provider or provider's office and obtain verification of the condition prior to enrollment, <u>or</u>

2) Utilize a CMS-approved pre-enrollment qualification assessment tool prior to enrollment and obtain verification of the condition from the provider or provider's office on a post-enrollment basis.

For either method, verification from the provider can be in the form of a note from a provider or the provider's office, or documented telephone contact with the provider or provider's office confirming that the individual has the condition. The organization may need to obtain written permission (separately from the enrollment form) permitting it to contact the beneficiary's provider's office to obtain verification of the condition.

If the organization chooses to use a CMS-approved prequalification assessment tool, it has until the end of the first month of enrollment to confirm that the enrollee has the qualifying condition necessary for enrollment into the severe/chronic disabling condition SNP. If it cannot confirm that the enrollee has the qualifying condition within that time, the organization has the first seven calendar days of the following month (i.e., the second month of enrollment) in which to send the beneficiary notice of his/her disenrollment at the end of that month for not having the qualifying condition. Disenrollment is effective at the end of the second month of enrollment; however, the organization must retain the member if confirmation of the qualifying condition is obtained at any point during the second month of enrollment. In the event the organization submits a disenrollment request to CMS prior to confirming the qualifying condition, a reinstatement request must be submitted to CMS (or its designee). The beneficiary has an SEP that begins with the month of notification and continues through the two following months to enroll in another MA organization for a prospective effective date. This SEP allows a beneficiary time to find a new plan while reducing the potential for incurring a late enrollment penalty.

> EXAMPLE: A beneficiary submits a request to enroll in a SNP effective March 1st. The SNP uses a CMS-approved prequalification assessment tool in February and attempts to confirm the beneficiary's special needs status but is unable to do so by March 31st. Between April 1st and April 7th (inclusive), the SNP must send a notice of prospective disenrollment to the beneficiary indicating April 30th as the disenrollment date. If the beneficiary fails to select a new plan by April 30th, his/her SEP will continue through June 30th. S/he can enroll in a plan effective June 1st or July 1st.

30 - Election Periods and Effective Dates

42 CFR 422.62 & 422.68

In order for an MA organization to accept an election, a valid request must be made during an election period (see §10 for the definition of "election"). It is the responsibility of the organization to determine the election period of each enrollment or disenrollment request. To make this determination, the organization may need to contact the individual directly. The plan may incorporate specific statements regarding eligibility of an election period with the enrollment or disenrollment request (see Exhibit 1a for optional use with enrollment mechanisms). However, if this information is not provided with the request, the plan must attempt to contact the individual by phone or other communication mechanism, and determine within the seven (7) day requirement if s/he is eligible to make an election at that time (see Exhibits 5 & 11a). Use of Exhibit 5 for the sole purpose of requesting information regarding an applicant's eligibility for an election period must include a due date that is no later than seven calendar days from the date the enrollment request was received.

Enrollment requests the plan is not denying must be submitted to CMS within seven (7) calendar days of the plan's receipt of the completed enrollment request. (Section 40.3)

Note: An organization's determination about an individual's eligibility for an election period is separate from a determination regarding whether an enrollment/disenrollment request is complete. See Section 40.2.2 for information pertaining to incomplete enrollment requests.

There are six types of election periods during which individuals may make enrollment requests. They are:

- The Annual Election Period (AEP);
- The Initial Coverage Election Period (ICEP);
- Initial Enrollment Period for Part D (IEP for Part D)[1]
- The Open Enrollment Period for Institutionalized Individuals (OEPI)
- All Special Election Periods (SEP); and
- The Medicare Advantage Disenrollment Period (MADP)

Unless a CMS-approved capacity limit or a CMS-issued enrollment sanction applies, all MA organizations must accept requests to enroll in their MA plans (with the exception of Medicare MSA plans) during the AEP, an ICEP, an IEP for Part D (MA-PD plans only) and any SEP that allows enrollment into the specific plan. (Refer to §30.7 for election periods for Medicare MSA plans.) When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until the limit is lifted. Refer to §30.9 and §30.9.1 for more information on OEPI plan closures, capacity limits and reserved vacancies.

[1] For MA, allows enrollment requests for MA-PD plans only.

30.1 - Annual Election Period (AEP)

During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. The last enrollment request made, determined by the application date, will be the enrollment request that takes effect (refer to §60.1 for information on multiple transactions).

Beginning in 2011, the AEP is from October 15 through December 7 of every year. The AEP is also referred to as the "Fall Open Enrollment" season and the "Open Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage" in Medicare beneficiary publications and other tools. MA organizations may use these descriptions of the AEP in their member materials, as well as in materials for prospective members.

Note: An employer/union sponsored MA plan may have an "open season" as determined by the employer. This may or may not correspond with the MA annual election period Therefore, organizations are not required to accept enrollment requests into employer/union plans during the AEP (unless the AEP and open season occur simultaneously); however, organizations must accept valid requests for disenrollment.

30.2 - Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of:

1. The last day of the month preceding entitlement to both Part A and Part B, or;

2. The last day of the individual's Part B initial enrollment period.

The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility. See 42 CFR 407.14 for additional information.

Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.

EXAMPLES

- Mrs. Donovan's 65th birthday is June 20, 2009. She is eligible for Medicare Part A and Part B beginning June 1, 2009 and has decided to enroll in Part B beginning on June 1. Her ICEP begins on March 1, 2009 and ends on September 30, 2009.

- Mrs. Smith's 65th birthday is April 20, 2008. She is eligible for Medicare Part A and Part B beginning April 1, 2008. Because she is still working and has health insurance provided by her employer, she has decided not to enroll in Part B during her initial enrollment period for Part B. Upon retiring, she will have the opportunity to enroll in Part B (through a Part B SEP). She has enrolled in Part B effective May 1, 2009. Her ICEP would be February 1 through April 30, 2009.

Please note that the ICEP for an MA enrollment election will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must always relate to the

individual's entitlement to both Medicare Part A and Part B. When an individual enrolls in an MA-PD plan, s/he has used both the ICEP and the IEP for Part D (see §30.2.1).

30.2.1 - Initial Enrollment Period for Part D (IEP for Part D)

The Initial Enrollment Period for Part D (IEP for Part D) is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when he or she is entitled to Part A OR is enrolled in Part B, AND permanently resides in the service area of a Part D plan. Ultimately, CMS provides a part D eligibility effective date and maintains it in CMS systems.

At the beginning of the Medicare prescription drug coverage program, all current Part D eligible individuals had an IEP for Part D that began on November 15, 2005, and ended on May 15, 2006. During the IEP for Part D, individuals may make one Part D enrollment choice, including enrollment in an MA-PD plan.

Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B. The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility. See 42 CFR 407.14 for additional information.

> EXAMPLE: Mr. Hackerman's 65th birthday is March 23, 2010. He is currently working, and while he signed up for his Medicare Part A benefits, effective March 1, 2010, he declined his enrollment in Part B, given his working status. He is eligible for Part D since he has Part A and lives in the service area. Even though he did not enroll in Part B, his Part B IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, December 2009 – June 2010. Hence, his IEP for Part D is also December 2009 – June 2010.

Individuals not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B have an IEP for Part D that is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility for Part D.

> EXAMPLE: Mr. Duke lived in Italy at the time of his 65th birthday, which occurred on August 3, 2008. His Part B initial enrollment period began on May 1, 2008, and ended November 30, 2008. He plans to return to the U.S. to reside permanently in June 2010. Since he lived out of the U.S. and was not eligible to enroll in a Part D plan during his IEP for Part B, his initial enrollment period for Part D will occur when he meets all the eligibility requirements for Part D, that is, when he has Part A or B and resides in a Part D plan service area. His IEP for Part D is March 2010 – September 2010.

Individuals eligible for Medicare prior to age 65 (such as for disability) will have another Initial Enrollment Period for Part D based upon attaining age 65.

The ICEP and the IEP for Part D occur together as one period when a newly Medicare eligible individual has enrolled in BOTH Part A and B at first eligibility. Should an individual delay enrollment in Part B to a later time, the ICEP and IEP for Part D become separate with the ICEP changing to then occur as the 3 months immediately preceding entitlement to BOTH parts A and B.

If a Medicare entitlement determination is made retroactively eligibility for Part D begins with the month in which the individual received notification of the retroactive entitlement decision. Therefore, the Part D IEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for three additional months after the month the notice is provided. The effective date is generally the first day of the month after the organization receives a completed enrollment request.

In MA context, the IEP for Part D applies only to MA-PD enrollment requests. Accordingly, when an applicant has both the ICEP and IEP for Part D available to him/her, the organization must submit the transaction to CMS as an IEP for Part D election. Refer to Chapter 3 of the Medicare Prescription Drug Benefit Manual for additional information regarding Part D election periods.

30.3 - Open Enrollment Period for Institutionalized Individuals (OEPI)

The OEPI is continuous for eligible individuals. For purposes of enrollment under the OEPI election period, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution, as defined in §10. The OEPI ends two months after the month the individual moves out of the institution.

> **Special Note for SNP enrollment:** In addition, the OEPI is available for individuals who meet the definition of "institutionalized" to enroll in or disenroll from an MA SNP for institutionalized individuals.

An MA eligible institutionalized individual can make an unlimited number of MA enrollment requests during the OEPI. An MA organization is not required to accept requests to enroll into its plan during the OEPI, but if it is open for these enrollment requests, it must accept all OEPI requests to enroll into the plan.

Since the OEPI is continuous for eligible individuals, Original Medicare is also open continuously. Therefore, MA organizations must accept requests for disenrollment from their MA plans during the OEPI whether or not the MA plan is open to accept enrollment.

Please note the definition of "institution" here differs from that used in determining when an institutionalized full-benefit dual eligible qualifies for the low-income subsidy copayment level of zero.

30.4 - Special Election Period (SEP)

Special election periods constitute periods outside of the usual IEP, AEP or MADP when an individual may elect a plan or change his or her current plan election. As detailed below, there are various types of SEPs, including SEPs for dual eligibles, and for individuals whose current plan terminates, who change residence and who meet "exceptional conditions" as CMS may provide, consistent with §1851(e)(4) of the Act and §422.62(b) of the MA regulations.

Depending on the nature of the particular special election period, an individual may:

- Discontinue an enrollment in an MA plan and enroll in Original Medicare
- Switch from Original Medicare to an MA plan
- Switch from one MA plan to another MA plan

Certain SEPs are limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may subsequently elect a new MA plan within the SEP time period. Once the individual has elected the new MA plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the SEP for the individual ends when the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.**

Note: An individual's eligibility for an SEP provides an opportunity to make an election but does not convey eligibility to enroll in the plan; an individual must also meet all applicable MA eligibility criteria.

It is generally the responsibility of the organization to determine whether the individual is eligible for an SEP. The exception to this determination requirement would be enrollment and disenrollment requests completed or approved by CMS staff. To make this determination, the organization may need to contact the individual directly. The plan may incorporate specific statements regarding eligibility of an SEP with the enrollment or disenrollment request (see Exhibit 1a for optional use with enrollment mechanisms and Exhibit 10a for optional use with disenrollment forms). However, if this information is not provided with the request, the plan must contact the individual to determine if they are eligible to make an election at that time. Unless stated otherwise in this guidance, the organization MUST accept an individual's verbal or written confirmation regarding the conditions that make him or her eligible for the SEP. Determination of eligibility for some SEPs requires that the organization obtain the date on which the individual's circumstances changed (i.e. change in residence, loss of special needs status, etc.). Organizations that obtain this information on the enrollment or disenrollment request are not required to obtain an additional verbal or written confirmation of SEP eligibility.

For enrollment requests obtained during a face-to-face interview or telephone request, the determination of SEP eligibility can be made at that time. For enrollment requests made using paper, or via the internet or the Medicare OEC (without accompanying CMS approval), the organization is not required to contact the applicant to confirm SEP eligibility if the enrollment request includes the applicant's attestation of SEP eligibility.

If SEP eligibility is obtained orally (by phone or in person), the organization must document this contact and retain this information with the enrollment or disenrollment record. If the organization obtains this confirmation through a written notice, such notice must afford the beneficiary the option of calling the organization and confirming this information verbally. If the organization is not able to obtain SEP eligibility information from the applicant, the organization must deny the enrollment or disenrollment request and provide the individual a denial notice (see Exhibit 7).

The following are examples of questions that might be used to determine eligibility for an SEP:

Type of SEP?	Examples of Questions
Change in Residence	Have you recently moved? If so, when? Where did you move from?
Employer/Union Group Health Plan (EGHP)	Do you currently have (or are leaving) coverage offered by an employer or union? Have you recently lost such coverage?

Disenroll from Part D to enroll in Creditable Coverage	Are you a member of TriCare? Do you have or want to obtain VA benefits?
Full and Partial Dual Eligible	Do you currently have Medicaid coverage? Did you recently receive a yellow letter from CMS? Does your state pay for your Medicare premiums? Have you recently lost coverage under Medicaid?
Other Low Income Subsidy	Have you recently been approved for extra help? Have you recently received a green letter from CMS? Do you receive SSI cash benefits without Medicaid? Did you receive a letter from Medicare letting you know that you automatically qualify for extra help? How much do you pay for your prescriptions?
Retroactive notice of Medicare entitlement	Have you recently received a notice telling you that you have been approved for Medicare for a "retroactive" date? If so, when did you receive this notice?
PACE	For enrollment – are you currently enrolled in a special plan called "PACE"?

Please note that the time frame of an SEP denotes the time frame during which an individual may make an enrollment or disenrollment request. It does not necessarily correspond to the effective date of coverage. For example, if an SEP exists for an individual from May - July, then an MA organization must receive an enrollment request from that individual sometime between May 1 and July 31 in order to consider the enrollment request an SEP enrollment request. However, the type of SEP will dictate what the effective date of coverage may be, and that effective date of coverage may be some time after July 31. The following discussion of SEPs and their corresponding effective dates will demonstrate this concept more fully.

Individuals who disenroll from an MA plan to Original Medicare during an SEP may be provided Medigap guaranteed issue rights. These rights are not afforded to those individuals who enroll into an MA plan during an SEP. MA organizations are required to notify members of these guaranteed issue rights when members disenroll to Original Medicare during a SEP. See §§50.1.7 and 50.2 for the additional information regarding these notification requirements

The time frames and effective dates for SEPs are discussed in the following sections. SEPs apply to local and regional MA-PD plans unless otherwise specifically stated. Corresponding SEPs for enrollment in Prescription Drug Plans (PDPs) are provided in separate PDP Enrollment guidance.

30.4.1 - SEPs for Changes in Residence

An SEP for a change in residence exists for these scenarios:

1) individuals who are no longer eligible to be enrolled in an MA plan due to a change in permanent residence outside of the MA plan service area;

2) individuals who were not eligible for MA because they were incarcerated and have now been released, or;

3) individuals who will have new Medicare health or Part D plans available to them as a result of a permanent move.

The SEP permits enrollment elections only; it begins on either the date of the permanent move or on the date the individual provides notification of such move. Since individuals who do not permanently reside in the plan service area are ineligible for the plan and must be disenrolled, a SEP is not needed to effectuate an involuntary disenrollment for that reason (see §50.2.1). Individuals who move and have new Medicare health or Part D plans available to them as a result of the move, but continue to reside in the current plan service area, may use this SEP to enroll in any MA or Part D plan for which they are eligible in their new place of residence. It is the individual's responsibility to notify the MA organization that he/she is permanently moving.

When the individual notifies the organization of a permanent move out of the plan service area, the SEP begins either the month before the individual's permanent move, if the individual notifies the organization in advance, or the month the individual provides the notice of the move, if the individual has already moved. The SEP continues for two months following the month it begins or the two months following the month of the move, whichever is later.

If the organization learns from CMS or another source (as described in §50.2.1.3) that the individual has been out of the service area for over six months and the organization has not been able to confirm otherwise with the individual, the SEP starts at the beginning of the sixth month and continues through to the end of the eighth month.

The enrollment effective date is determined by the date the MA organization receives the enrollment request**.** The individual may choose an effective date of up to three months after the month in which the MA organization receives the enrollment request. However, the effective date may not be earlier than the date the individual moves to the new service area and the MA organization receives the enrollment request.

EXAMPLE 1

A beneficiary is a member of an MA plan in Florida and intends to move to Arizona on June 18. A SEP exists for this beneficiary from May 1 - August 31.

A. If an MA organization in Arizona receives an enrollment request from the beneficiary in May, the beneficiary can choose an effective date of July 1, August 1, or September 1.

B. If the MA organization receives the enrollment request from the beneficiary in June (the month of the move), the beneficiary can choose an effective date of July 1, August 1, or September 1.

C. If the MA organization receives the enrollment request in July, the beneficiary could choose an effective date of August 1, September 1, or October 1.

EXAMPLE 2

A beneficiary resides in Florida and is currently in Original Medicare and not enrolled in an MA plan. The individual intends to move to Maryland on August 3. An SEP exists for this beneficiary from July 1 through October 31.

At the time the individual makes the enrollment request into an MA plan, the individual must provide the specific address where the individual will permanently reside upon moving into the service area, so that the MA organization can determine that the individual meets the residency requirements for enrollment in the plan.

Disenrollment from Previous MA Plan

Please keep in mind that a member of an MA plan who moves permanently out of the service area must be involuntarily disenrolled from the plan, unless continuation of enrollment applies. A member of an MA plan who is out of the service area for over six months must be involuntarily disenrolled from the plan.

CMS has established an SEP that allows an individual adequate time to choose a new MA plan, given the fact that the individual will no longer be enrolled in the original MA plan after the month of the move or after the sixth month (whichever is appropriate). Unless an individual enrolls in a new MA plan with an effective date of the month after the move or the beginning of the seventh month (e.g., the individual moves on June 18 and enrolls in a new plan effective July 1), he/she will be enrolled in Original Medicare until he/she elects the new MA plan during a valid enrollment period. If the individual had Part D coverage and lost it due to the involuntary disenrollment, s/he may be subject to a Part D late enrollment penalty (LEP). See Chapter 4 of the Medicare Prescription Drug Manual for more information.

30.4.2 - SEPs for Contract Violation

In the event an individual is able to demonstrate to CMS that the MA organization offering the MA plan of which he/she is a member substantially violated a material provision of its contract under MA in relation to the individual, or the MA organization (or its agent) materially misrepresented the plan when marketing the plan, the individual may disenroll from the MA plan and elect Original Medicare or another MA plan. The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately elects a new MA plan upon disenrollment from the original MA plan or whether the individual initially elects Original Medicare before choosing a new MA plan.

We note that in some case-specific situations, CMS may process a retroactive disenrollment for these types of disenrollments. If the disenrollment is not retroactive:

- A SEP exists such that an individual may elect another MA plan or Original Medicare during the last month of enrollment in the MA organization, for an effective date of the month after the month the new MA organization receives the enrollment request.

EXAMPLE

On January 16, CMS determines, based on a member's allegations, that the MA organization substantially violated a material provision of its contract. As a result, the member will be disenrolled from the MA plan on January 31. A SEP exists for this beneficiary beginning January 16 and lasting until the end of January. The beneficiary promptly applies for a new MA plan, and the new MA organization receives the enrollment form on January 28 for a February 1 effective date.

- If the individual in the above example elected Original Medicare during the last month of enrollment in the MA organization (either by choosing Original Medicare or by not choosing an MA plan and therefore defaulting to Original Medicare), the individual will be given an additional 90 calendar days from the effective date of the disenrollment from the MA organization to elect another MA plan. During this 90-day period, and until the individual elects a new MA plan, the individual will be enrolled in Original Medicare. The individual may choose an effective date into a new MA plan beginning any of the three months after the month in which the MA organization receives the enrollment request. However, the effective date may not be earlier than the date the MA organization receives the enrollment request.

  EXAMPLE

  On January 16, CMS determines, based on a member's allegations that the MA organization substantially violated a material provision of its contract. The member decides to return to Original Medicare. As a result, the member is disenrolled from the MA plan on January 31 and enrolled in Original Medicare with a February 1 effective date. A 90-day SEP continues to exist for the beneficiary from February 1 through April 30. In this example, a new MA organization then receives an enrollment request from the individual on April 15. The beneficiary can choose an effective date of May 1, June 1, or July 1.

If the disenrollment is retroactive, CMS will provide the beneficiary with the time frame for his/her SEP to elect another plan on a case-by-case basis. Depending on the circumstances surrounding the contract violation, CMS may determine a retroactive enrollment into another MA plan is warranted.

30.4.3 - SEPs for Non-renewals or Terminations

In general, SEPs are established to allow members affected by non-renewals or terminations ample time to elect a new plan. Effective dates during these SEPs are described below. CMS has the discretion to modify this SEP as necessary for any non-renewals or terminations when the circumstances are unique and warrant a modified SEP.

In particular:

- **Non-renewals -** A SEP exists for members of MA plans that will be affected by plan or contract non-renewals and plan service area reductions that are effective January 1 of the contract year. In order to provide sufficient time for members to evaluate their options, the SEP begins December 8 and ends on the last day in February of the following year.

  Enrollment requests received from December 8 through December 31 will have an effective date of January 1. Enrollment requests received in January will have an effective

date of February 1. Enrollment requests received in February will have an effective date of March 1.

- **MA organization Termination of Contract and Terminations/Contract Modifications by Mutual Consent -** A SEP exists for members of plans who will be affected by a termination of contract by the MA organization or a modification or termination of the contract by mutual consent (42 CFR §§422.512 and 422.508(a)(1)). The SEP begins two months before the proposed termination effective date, and ends one month after the month in which the termination occurs.

  Please note that if an individual does not elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in effect for one month after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a current, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may request an effective date of the month after notice is given, or up to two months after the effective date of the termination. However, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

  EXAMPLE

  If an MA organization contract terminates for cause on April 30, an SEP lasts from March 1 through May 31. In this scenario, a beneficiary could choose an effective date of April 1, May 1, or June 1; however, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

- **CMS Termination of MA organization Contract -** A SEP exists for members of plans that will be affected by MA organization contract terminations by CMS (42 CFR 422.510). The SEP begins 1 month before the termination effective date and ends 2 months after the effective date of the termination.

  Please note that if an individual does not elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare on the effective date of the termination. However, the SEP will still be in effect for two months after the effective date of the termination should the individual wish to subsequently elect an MA plan (for a current, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may select an effective date of up to three months after the month of termination. However, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

  EXAMPLE

  If CMS terminates an MA organization contract effective June 30, an SEP lasts from June 1 through August 31. In this scenario, a beneficiary could choose an effective date of July 1, August 1, or September 1; however, the effective date may not be earlier than the date the new MA organization receives the enrollment request.

- **Immediate Terminations By CMS -** CMS will establish the SEP during the termination process for immediate terminations by CMS (§422.510(b)(2)), where CMS provides notice of termination to an MA plan's members and the termination may be mid-month.

Note: Approved plan consolidations are neither terminations nor non-renewals. Thus individuals affected by plan consolidations are not eligible for the SEP for non-renewals or terminations. Please see the annual CMS Call Letter and other CMS end-of-year guidance for more information about approved plan consolidations.

30.4.4 - SEPs for Exceptional Conditions

CMS has the legal authority to establish SEPs when an individual or group of individuals meets exceptional conditions specified by CMS, including on a case-by-case basis. The SEPs CMS has established include:

1. SEP EGHP (Employer/Union Group Health Plan) - An SEP exists for individuals making MA enrollment requests into or out of employer sponsored MA plans, for individuals to disenroll from an MA plan to take employer sponsored coverage of any kind, and for individuals disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan. The SEP EGHP may be used when the EGHP allows the individual to make changes in their health coverage choices, such as during the employer's or union's "open season," or at other times the employer or union allows. This SEP is available to individuals who have (or are enrolling in) an employer or union sponsored plan and ends 2 months after the month the employer or union coverage ends.

The individual may choose an effective date of up to three months after the month in which the individual completed an enrollment or disenrollment request; however, the effective date may not be earlier than the first of the month following the month in which the request was made. The effective date also may not be earlier than the first day of the individual's entitlement to both Medicare Part A and Part B.

> **NOTE:** If necessary, the MA organization may process the enrollment request with a retroactive effective date, as outlined in §60.6. Keep in mind that all MA eligible individuals, including those in EGHPs, may elect MA plans during the AEP and ICEP and during any other SEP. The SEP EGHP does not eliminate the right of these individuals to make enrollment requests during these time frames.

Refer to §30.6 for additional information for situations in which an individual is determined eligible for more than one election period, one of which includes the SEP EGHP.

2. SEP for Individuals Who Disenroll in Connection with a CMS Sanction - On a case by case basis, CMS will establish an SEP if CMS sanctions an MA organization, and an enrollee disenrolls in connection with the matter that gave rise to that sanction. The start/length of the SEP, as well as the effective date, is dependent upon the situation.

3. SEP for Individuals Enrolled in Cost Plans that are Non-renewing their Contracts - An SEP will be available to enrollees of HMOs or CMPs that are not renewing their §1876 cost contracts for the area in which the enrollee lives.

This SEP is available only to Medicare beneficiaries who are enrolled with an HMO or CMP under a §1876 cost contract that will no longer be offered in the area in which the beneficiary

lives. Beneficiaries electing to enroll in an MA plan via this SEP must meet MA eligibility requirements.

This SEP begins December 8 of the current contract year and ends on the last day of February of the following year.

Enrollment requests received from December 8 through December 31 will have an effective date of January 1. Enrollment requests received in January will have an effective date of February 1. Enrollment requests received in February will have an effective date of March 1.

4. SEP for Individuals in the Program of All-inclusive Care for the Elderly (PACE) - Individuals may disenroll from an MA plan at any time in order to enroll in PACE. In addition, individuals who disenroll from PACE have an SEP for up to 2 months after the effective date of PACE disenrollment to elect an MA plan. The effective date would be dependent upon the situation.

5. SEP for Dual-eligible Individuals or Individuals Who Lose Their Dual-eligibility - There is an SEP for individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (e.g. QMB-only, SLMB-only, etc). This SEP begins the month the individual becomes dually-eligible and exists as long as s/he receives Medicaid benefits. This SEP allows an individual to enroll in, or disenroll from, an MA plan. The effective date of an enrollment request made using this SEP would be the first of the month following receipt of an enrollment request. However, as described in §40.1.5, the effective date for auto-enrollments of full-benefit dual-eligible individuals may be retroactive.

In addition, MA-eligible individuals who are no longer eligible for Title XIX benefits have an SEP beginning the month they receive notice of the loss of eligibility plus two additional months to make an enrollment choice in another MA plan.

6. SEP for Individuals Who Dropped a Medigap Policy When They Enrolled For the First Time in an MA Plan, and Who Are Still in a "Trial Period" - For Medicare beneficiaries who dropped a Medigap policy when they enrolled for the first time in an MA plan, §1882(s)(3)(B)(v) of the Act provides a guaranteed right to purchase another Medigap policy if they disenroll from the MA plan while they are still in a "trial period." In most cases, a trial period lasts for 12 months after a person enrolls in an MA plan for the first time. Such individuals would not be eligible for the special election period provided for in the last sentence of §1851(e) of the Act, because they did not enroll in an MA plan immediately upon becoming Medicare eligible, but instead had been in the Original Medicare Plan for some period of time. The right to "guaranteed issue" of a Medigap policy under §1882(s)(3)(B)(v) of the Act would be meaningless if individuals covered by this provision could not disenroll from the MA plan while they were still in a trial period.

Accordingly, there is an SEP for individuals who are eligible for "guaranteed issue" of a Medigap policy under §1882(s)(3)(B)(v) of the Act upon disenrollment from the MA plan in which they are enrolled. This SEP allows a qualified individual to make a one-time election to disenroll from their first MA plan to join the Original Medicare Plan at any time of the year. The SEP begins upon enrollment in the MA plan and ends after 12 months of enrollment or when the beneficiary disenrolls, whichever is earlier. The effective date would be dependent upon the situation.

7. SEP for Individuals with ESRD Whose Entitlement Determination Made Retroactively - If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an MA plan offered by the MA organization, provided:

a. They were in a health plan offered by the same MA organization the month before their entitlement to Parts A and B;

b. Developed ESRD while a member of that health plan; and

c. Are still enrolled in that health plan.

This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period AFTER dialysis begins.

The SEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for 2 additional months after the month the notice is received. The enrollment request may only be made prospectively and the effective date is the first day of the month after the MA plan receives the enrollment request.

8. SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively - If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to elect an MA plan offered by the MA organization. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely by SSA and/or received by the individual in a timely manner.

The SEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for two additional months after the month the notice is received. The effective date depends on the situation but is not earlier than the first day of the month in which the notice of the Medicare entitlement determination is received by the individual.

9. MA SEPs to Coordinate With Part D Enrollment Periods – Individuals eligible for an enrollment period under the guidance for Part D enrollment and disenrollment may use that SEP to make an election into or out of an MA-PD plan (as applicable). Most Part D SEPs are duplicated in the MA program as described above; however, those that are not described elsewhere are provided here:

A. Involuntary loss of creditable coverage, including a reduction in the level of coverage so that it is no longer creditable, not including any such loss or reduction due to a failure to pay premiums. The SEP permits enrollment into a Part D plan and begins with the month in which the individual is advised of the loss of creditable coverage and ends two months after either the loss (or reduction) occurs or the individual received notice, whichever is later. The effective date of this SEP may be the first of the month after the request or, at the beneficiary's request, may be prospective; however, it may be no more than 3 months prospective.

B. Individuals who are not adequately informed of a loss of creditable coverage, or that they never had creditable coverage, have an SEP to enroll in a Part D plan. The SEP permits one enrollment in, or disenrollment from, a Part D plan on a case-by-case basis. This SEP begins the month of CMS approval of this SEP and continues for two additional months following this approval.

C. Individuals whose enrollment or non-enrollment in a Part D plan is erroneous due to an action, inaction or error by a Federal Employee. The SEP permits disenrollment and/or enrollment in a Part D plan on a case-by-case basis. Requests for this SEP must be developed and presented to the CMS Regional Office serving the MA-PD plan for which the SEP will apply. This SEP begins the month of CMS approval of this SEP and continues for two additional months following this approval.

D. An individual eligible for an additional Part D IEP, such as an individual currently entitled to Medicare due to a disability and who is attaining age 65, has an MA SEP to coordinate with the additional Part D IEP. The SEP may be used to disenroll from an MA-only or MA-PD plan to Original Medicare, or to enroll in an MA-only plan (regardless of whether the individual uses the Part D IEP to enroll in a PDP). The SEP begins and ends concurrently with the additional Part D IEP.

For more information about PDP enrollment and disenrollment, please refer to the CMS guidance for PDPs.

10. SEP for Individuals Who Lose Special Needs Status - CMS will provide an SEP for individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status. This SEP begins when the period of deemed continued eligibility starts (per §50.2.5) and ends when the beneficiary makes an enrollment request or three months after the expiration of the period of deemed continued eligibility.

11. SEP for Individuals Who Belong to a Qualified SPAP or Who Lose SPAP Eligibility – Individuals who belong to a qualified State Pharmaceutical Assistance Program (SPAP) are eligible for an SEP to make one enrollment request at any time through the end of each calendar year (i.e. once per year). SPAP members may use this SEP to enroll in a Part D plan outside of existing enrollment opportunities, allowing them, for example, to join a Part D plan upon becoming a member of an SPAP or to switch to another Part D plan. In summary, a beneficiary may use this SEP to switch from an MA-PD plan to another PDP or MA-PD plan, from Original Medicare without a PDP to Original Medicare with a PDP or to an MA-PD plan, from a PDP to another PDP or MA-PD plan or from an MA-only plan (no prescription drug coverage) to a PDP or MA-PD plan. In addition, individuals no longer eligible for SPAP benefits will have an SEP beginning either the month they lose eligibility or are notified of the loss, whichever is earlier, and ends two months after either the month of the loss of eligibility or notification of the loss, whichever is later. This SEP permits an enrollment choice in another PDP or MA-PD.

12. SEP for Non-Dual Eligible Individuals with LIS and Individuals who Lose LIS - Individuals who qualify for LIS (but who do not receive Medicaid benefits) have an SEP that begins the month the individual becomes eligible for LIS and exists as long as s/he is eligible for LIS. This SEP allows an individual to enroll in, or disenroll from, a Part D plan at any time. Because this coverage is effective the first of the month, the SEP would permit beneficiaries to change enrollment on a monthly basis, if they so choose. The effective date for all enrollments under this SEP will be prospective, effective the first day of the month following the organization's receipt of the enrollment request.

Example: An individual is awarded LIS and CMS facilitates his enrollment into a PDP, effective October 1st. In November, the individual decides he would rather be enrolled in another PDP or an MA-PD plan and submits a request in November. He does so using this SEP and his enrollment is effective December 1st.

Individuals who lose their LIS eligibility for the following calendar year will have an SEP to make a change during January – March. Those individuals who lose eligibility for LIS during the year outside of this annual redeeming process will have an SEP that begins the month the MA organization notifies them of the loss of LIS and continues for two full calendar months.

13. SEP for Enrollment Into a Chronic Care SNP and for Individuals Found Ineligible for a Chronic Care SNP - CMS will provide an SEP (for MA and Part D) for those individuals with severe or disabling chronic conditions to enroll in a SNP designed to serve individuals with those conditions. This SEP will apply as long as the individual has the qualifying condition and will end once s/he enrolls in a SNP. Once the SEP ends, that individual may make enrollment changes only during applicable MA election periods. In addition, individuals enrolled in a Chronic Care SNP who have a severe/disabling chronic condition which is not a focus of their current SNP are eligible for this SEP. Such individuals have an opportunity to enroll in a Chronic Care SNP that focuses on this other condition. Eligibility for this SEP ends at the time the individual enrolls in the new SNP.

Individuals who are found after enrollment not to have the qualifying condition necessary to enroll in a Chronic Care SNP will have an SEP to enroll in a different MA-PD plan or an MA-only plan with accompanying Part D coverage. This would normally occur when the required post enrollment verification with a provider did not confirm the information provided on the pre-enrollment assessment tool. This SEP begins when the plan notifies the individual of the lack of eligibility and extends through the end of that month as well as the following two months. The SEP ends when the individual makes an enrollment election or on the last day of the second of the two months following notification. Any enrollments made during this election period are for prospective effective dates.

14. SEP for Disenrollment from Part D to Enroll in or Maintain Other Creditable Coverage - Individuals may disenroll from a Part D plan (including PDPs and MA-PDs) to enroll in or maintain other creditable drug coverage (such as TriCare or VA coverage). The effective date of disenrollment is the first day of the month following the month a disenrollment request is received by the Part D plan. Additionally, individuals enrolled in an MA-PD plan who have or are enrolling in other creditable coverage may use this SEP to disenroll from the MA-PD plan by enrolling in an MA-only plan.

15. SEP to Enroll in an MA Plan, PDP or Cost Plan With a Plan Performance Rating of Five (5) Stars – An eligible individual may enroll in an MA plan, PDP or cost plan with a Plan Performance Rating of five (5) stars during the year in which that plan has the 5-star overall rating, provided the enrollee meets the other requirements to enroll in that plan (e.g., living within the service area as well as requirements regarding end-stage renal disease). Individuals may use the 5-Star SEP to disenroll from a Medicare Advantage plan by enrolling in a 5-Star cost plan that is open for enrollment.

Example: Cost plan A has an overall rating of 5 stars for 2012 and is open for enrollment. An individual enrolled in a MA plan uses this SEP to enroll in cost plan A. Cost plan A

submits the enrollment transaction to MARx using the "R" election type code, and the MA plan B accepts and processes the subsequent disenrollment per the TRR.

As overall ratings are assigned for the plan contract year (January through December), possible enrollment effective dates are the first of the month from January 1 to December 1 during the year for which the plan has been assigned an overall rating of 5 stars. An individual may use this SEP only one time from December 8 through November 30 of the following year in which the organization has been granted a 5-star overall rating. The enrollment effective date is the first of the month following the month in which the plan receives the enrollment request.

Example: Plan X has an overall rating of 4.5 stars in 2012 and 5 stars for 2013. An individual could use this SEP to request enrollment in Plan X starting on December 8, 2012 for an effective date of January 1, 2013. An individual could not use the SEP to enroll in Plan X for an effective date on or before December 1, 2012, as the enrollment effective dates available during that period are prior to the calendar year for which Plan X has been assigned a 5-star overall rating.

Example: Plan Y has an overall rating of 5 stars for 2013 but has lost that 5-star rating for 2014. A beneficiary could use this SEP to request enrollment in Plan Y for the first of the following month until November 30, 2013, with the last possible effective date available being December 1, 2013. The beneficiary could not use the SEP to enroll in Plan Y on or after December 1, 2013, as the enrollment effective dates available during that period are after the calendar year for which Plan Y has been assigned a 5-star overall rating.

Eligible individuals can switch from an MA plan, a PDP, a cost plan or Original Medicare to an MA-only plan, an MA-PD plan, a PDP or a cost plan that has a 5-star overall rating.

An individual using this SEP can enroll in an MA-only plan, an MA-PD plan, a cost plan or a PDP with a 5-star overall rating even if coming from Original Medicare (with or without concurrent enrollment in a PDP). Individuals enrolled in a plan with a 5-star overall rating may also switch to a different plan with a 5-star overall rating. An individual in an MA-only or MA-PD coordinated care plan who switches to a PDP with a 5-star overall rating will lose MA coverage and will revert to Original Medicare for basic medical coverage.

Regardless of whether the individual has Part D coverage prior to use of this SEP, any individual who enrolls in a 5-star Medicare Advantage private Fee-for-Service plan without prescription drug coverage or a 5-star cost plan is eligible for coordinating Part D SEP to enroll in a PDP. (See Chapter 3, Section 30.3.8 #8, letter H of the Medicare Prescription Drug Benefit Manual for more information.)

Note that use of this SEP does not guarantee Part D coverage. If an individual in either an MA-PD plan or a PDP chooses to enroll in an MA-only coordinated care plan with a 5-star overall rating, that individual would lose Part D coverage and must wait for a subsequent enrollment period to obtain Part D coverage under the normal enrollment rules. Late enrollment penalties might also apply.

30.4.5 - SEPs for Beneficiaries Age 65 (SEP65)

MA eligible individuals who elect an MA plan (other than an MSA plan) during the initial enrollment period (IEP) for Part B surrounding their 65th birthday have an SEP. This "SEP65"

allows the individual to disenroll from this MA plan and elect the Original Medicare plan any time during the 12-month period that begins on the effective date of coverage in the MA plan.

The IEP for Part B is established by Medicare and begins 3 months before and ends 3 months after the month of the individual's 65th birthday. Individuals entitled to Medicare prior to age 65 are not eligible for the SEP65.

30.5 – Medicare Advantage Disenrollment Period (MADP)

MA plan enrollees have an annual opportunity to prospectively disenroll from any MA plan and return to Original Medicare between January 1 and February 14 of every year. The effective date of a disenrollment request made using the MADP will be the first of the month following receipt of the disenrollment request. A request made in January will be effective February 1, and a request made in February will be effective March 1. The MADP does not provide an opportunity to join or switch MA plans.

Regardless of whether the MA plan included Part D drug coverage, MA enrollees using the MADP to disenroll from MA from January 1 through February 14 are eligible for a coordinating Part D SEP to enroll in a PDP and may request enrollment in a PDP at any time during the MADP (see §30.3.8 of Chapter 3 of the Medicare Prescription Drug Manual). An individual may use this SEP to request enrollment in a PDP subsequent to having submitted a disenrollment request from the MA plan during the MADP or may simply request enrollment in the PDP, resulting in automatic disenrollment from the MA plan. If the individual uses the coordinating Part D SEP to request enrollment in a PDP, the enrollment effective date is the first of the month following the PDP sponsor's receipt of the enrollment request. Individuals enrolled in MA-only PFFS plans must request disenrollment from the MA-only plan in order to be eligible for this SEP, as enrollment in a PDP will not result in automatic disenrollment from the MA-only plan.

30.6 - Effective Date of Coverage

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their enrollment effective date. Furthermore, except for EGHP enrollment requests, the effective date is generally not prior to the receipt of an enrollment request by the MA organization. An enrollment cannot be effective prior to the date the beneficiary or his/her legal representative signed the enrollment form or submitted the enrollment request. §40.2 includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section. The effective date also may not be earlier than the first day of the individual's entitlement to both Medicare Part A and Part B.

To determine the proper effective date, the MA organization must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the enrollment request is received by the MA organization.

Once the election period is identified by the MA organization, the MA organization must determine the effective date. Refer to §60.8 to determine the effective date for a continuation of enrollment. In addition, EGHP enrollments may be retroactive (refer to §60.6 for more information on EGHP retroactive effective dates).

Effective dates are as follows:

Election Period	**Effective Date of Coverage**	**Do MA organizations have to accept enrollment requests in this election period?**
Initial Coverage Election Period and Initial Enrollment Period for Part D	First day of the month of entitlement to Medicare Part A and Part B – or- The first of the month following the month the enrollment request was made if after entitlement has occurred.	Yes – unless capacity limit applies (see §30.9 for capacity limit information). IEP for Part D is applicable only to MA-PD enrollment requests.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request	No - the MA organization can choose to be "open" or "closed" for enrollments during this period.
Annual Election Period	January 1 of the following year	Yes – unless capacity limit applies
Special Election Period	Varies, as outlined in §30.4	Yes – unless capacity limit applies

It is possible for an individual to make an enrollment request when s/he is eligible for more than one election period, resulting in more than one possible effective date. Therefore, if an organization receives an enrollment request and determines the applicant is eligible for more than one election period, the organization must allow the individual to choose the enrollment effective date (see exception in the next paragraph regarding the ICEP). To accomplish this, the organization must attempt to contact the individual, and must document its attempt(s), to determine the individual's preferred effective date. **Note:** This requirement does not apply to beneficiary requests for enrollment into an employer/union sponsored plan using the group enrollment mechanism, as these may be submitted to CMS with the EGHP SEP election type code.

If one of the election periods for which the individual is eligible is the ICEP, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and Part B.

EXAMPLE

If an individual will be entitled to Medicare Part A and Part B in February his ICEP is November through May. If an MA organization receives an enrollment request from that individual during the AEP, the individual may NOT choose a January 1 effective date and must be given a February 1 effective date for the ICEP because January 1st is earlier than the month of entitlement to Medicare Part A and Part B.

If an individual is eligible for more than one election period but does not indicate a preferred effective date or the organization is unable to contact the individual, the organization must assign an effective date using the following ranking of election periods. The election period with the highest rank generally determines the effective date of enrollment (refer to §30.7 for procedures to determine the effective date of voluntary disenrollment).

Individuals eligible for the SEP EGHP and one or more other election periods who make an election via the employer or union election process will be assigned an effective date according to the SEP EGHP, unless the individual requests a different effective date that is allowed by one of the other elections periods for which s/he is eligible.

Ranking of Election Periods: (1 = Highest, 4 = Lowest)

1. ICEP/IEP-D
2. SEP
3. AEP/MADP
4. OEPI

30.6.1 - Effective Date of Auto- and Facilitated Enrollments

The effective dates for auto-enrollment and facilitated enrollment are described in §40.1.5 of this chapter.

30.7 - Effective Date of Voluntary Disenrollment

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not select their effective date of disenrollment. §50.1 includes procedures for handling situations when a beneficiary chooses a disenrollment effective date that is not allowable based on the requirements outlined in this section.

When a member disenrolls through the MA organization or 1-800-MEDICARE, the enrollment request will return the member to Original Medicare. If a member elects a new MA plan while still a member of a different plan, he/she will automatically be disenrolled from the old plan and enrolled in the new plan by CMS systems with no duplication or delay in coverage.

As with enrollments, it is possible for a member to make a disenrollment request when more than one election period applies. Therefore, in order to determine the proper effective date, the MA organization must determine which election period applies to each member before the disenrollment may be transmitted to CMS.

If an MA organization receives a disenrollment request when more than one election period applies, the MA organization must allow the member to choose the effective date of disenrollment. If the member does not make a choice of effective date, then the MA organization must give the effective date that results in the **earliest** disenrollment.

Effective dates for voluntary disenrollment are as follows (refer to §§50.2 and 50.3 for effective dates for involuntary disenrollment).

Election Period	Effective Date of Disenrollment*	Do MA organizations have to accept disenrollment requests in this election period?
Medicare Advantage Disenrollment Period	First day of the month after the month the MA organization receives the disenrollment request.	MA plans (except for MSA) must accept requests for voluntary disenrollment because Original Medicare is always open during this election period.
Annual Election Period	January 1 of the following year.	Yes
Special Election Period	Varies, as outlined in §30.4	Yes
Open Enrollment Period for Institutionalized Individuals	First day of the month after the month the MA organization receives the disenrollment request.	Yes

***NOTE:** CMS may allow up to 90 days retroactive payment adjustments for EGHP disenrollments. Refer to §60.6 for more information.

30.8 - Election Periods and Effective Dates for Medicare MSA Plans

Individuals may enroll in Medicare MSA plans (should one be offered in their area) only during the ICEP or the AEP; they may not enroll in Medicare MSA plans during a SEP (see exception below). The effective date of coverage is determined by the election period in which an enrollment request is made. Effective dates are provided in §30.6 of this chapter.

Individuals may disenroll from Medicare MSA plans only during the AEP or an SEP. The effective date of disenrollment during an SEP depends on the type of SEP. Additionally, MSA enrollees may not use the MADP to disenroll from the MSA.

> **Exception:** To facilitate the offering of employer/union sponsored MSA plans, CMS will permit individuals to request enrollment into an employer/union sponsored MSA plan using the Employer Group Health Plan Special Enrollment Period (EGHP SEP).

30.9 - Closed Plans, Capacity Limits, and Reserved Vacancies

An MA organization may specify a capacity limit for one or all of the MA plans it offers and reserve spaces for individual and employer or union group commercial members who are converting from a commercial product to an MA product at the time the member becomes eligible (i.e., conversion enrollments). When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until space becomes available.

All MA plans (with the exception of Medicare MSA plans; see §30.8) must accept enrollment requests made during the AEP, ICEP and SEP unless an approved capacity limit applies. Only with an approved number of reserved vacancies may an MA organization set aside openings for the enrollment of conversions (i.e., ICEP enrollment requests).

Unlike the mandatory election periods (AEP, ICEP and SEP), an MA organization has the option to voluntarily close one or more of its MA plans to OEPI enrollment requests. If an MA plan is closed for OEPI enrollments, then it is closed to all individuals in the entire plan service area who are making OEPI enrollment requests. All MA plans must accept OEPI disenrollment requests, regardless of whether or not it is open for enrollment.

> **NOTE**: For purposes of auto-enrollment and facilitated enrollment, MA organizations must ensure that the MA-PD plans into which beneficiaries are deemed to have enrolled have the capacity to accept them. Should a capacity limit be proposed for an MA-PD plan, it must be set high enough to ensure all beneficiaries may be transitioned.

30.9.1 - MA Plan Closures

The decision to be open or closed for OEPI enrollment requests rests with the MA organization and does not require CMS approval. However, if an MA organization has an MA plan that is open for OEPI enrollment requests, and decides to change this process, it must notify CMS and the general public 30 calendar days in advance of the new limitations on the open enrollment process.

If an MA organization has more than one MA plan, those plans may be open or closed to OEPI enrollment requests independent of one another, as the MA organization determines. Further, each MA plan may be open for OEPI enrollment requests:

1. Only certain months of the year;

2. Some portion of certain months; and/or

3. During the first 25 days (or any part) of each month.

When an MA plan is voluntarily closed for OEPI enrollments, it is closed to **ALL** OEPI enrollment requests, but it must still accept enrollment requests made during the ICEP and SEP as well as be open for the AEP, unless an approved capacity limit applies and has been reached (excluding reserved vacancies). CMS may approve a partial service area closure for capacity reasons. If a plan is closed in a portion of its service area for capacity reasons, that plan may be open for OEPI enrollments in the remaining portion of the service area.

When an MA plan is closed due to an approved capacity limit that has been reached, it may continue to accept ICEP (i.e., conversion) enrollments only if there are reserved vacancies set aside. If there are no reserved vacancies, or once all of these vacancies have been filled, the MA organization cannot accept any new enrollees into the MA plan until space becomes available. Refer to §40.5.1 for more information on enrollment processing after reaching capacity.

Refer to §40.5 of this chapter for additional information on enrollment processing during closed periods.

If an MA organization has an MA plan that is approved by CMS for a capacity limit, it should estimate when a capacity limit will be reached and notify CMS and the general public 30 calendar days in advance of the closing of the open enrollment process. If CMS approves the capacity limit for immediate closing of enrollment, the MA organization must notify the general public within 15 calendar days of CMS approval that it has closed for enrollment.

Exhibit 23 contains three model notices that MA organizations can use to notify the public when they are closing for enrollment. **NOTE:** Public notices must receive CMS approval under the usual marketing review process.

When an MA organization has a plan that re-opens after being closed to OEPI enrollment requests or as a result of a capacity limit, there is no requirement for the MA organization to notify the general public. However, the MA organization should notify CMS when this occurs.

40 - Enrollment Procedures

42 CFR 422.66

An MA organization must accept enrollment requests it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS.

An individual (or his/her legal representative) must complete an enrollment request mechanism to enroll in an MA plan and submit the enrollment request to the MA plan during a valid enrollment period. If an individual wishes to elect another MA plan in the same parent organization, he/she must complete a new enrollment request to enroll in the new MA plan. Enrollment may also be made via Auto- and Facilitated enrollment processes as described in §40.1.5 of this chapter and via the group enrollment process for employer or union sponsored plans as described in §40.1.6.

Upon receiving an enrollment request, an MA organization must provide within 10 calendar days, one of the following:

- Acknowledgement notice (as described in section 40.4.1);
- Request for additional information (as described in 40.2.2); or
- Notice of denial (as described in 40.2.3).

If a plan uses the combined acknowledgment/confirmation notice, the plan may send the notice of rejection within 7 calendar days of receiving the Transaction Reply Report (TRR) indicating a rejection instead of sending the above items (as described in 40.4.2).

Unless otherwise directed in this guidance, the organization must provide required notices in response to information received from CMS on the TRR that contains the earliest notification.

MA organizations may not delay the processing of enrollment requests unless the beneficiary's enrollment request is being placed on a waiting list, as allowed under §40.5.

Refer to §40.2.5 for MA-PD enrollments in which an individual has other qualified prescription drug coverage through an employer or union group.

Special Rule for the Annual Election Period (AEP):

Medicare Advantage (MA) organizations may not solicit submission of paper enrollment forms or accept telephone or on-line enrollment requests prior to the beginning of the AEP. Brokers and agents under contract to MA organizations may not accept or solicit submission of paper enrollment forms prior to the start of the AEP. MA organizations and their brokers and agents also should remind beneficiaries that they cannot submit enrollment requests prior to the start of the AEP.

Despite these efforts, CMS recognizes that MA organizations may receive unsolicited paper enrollment forms prior to the start of the AEP, given that marketing activities may begin prior to this date. *To be considered unsolicited, the MA organization must have received the paper AEP enrollment request directly from the applicant and not through a sales agent or broker. Other enrollment request mechanisms may not be accepted prior to the actual start of the AEP. Paper AEP enrollment requests received prior to the start of the AEP for which there is indication of sales agent or broker involvement in the submission of the request (i.e., the name or contact*

information of a sales agent or broker) must be investigated by the organization for compliance with the requirements in the Medicare Marketing Guidelines. If an MA organization receives unsolicited paper enrollment forms on or after October 1st but prior to the start of the AEP, it must retain and process them as follows:

- Within 7 calendar days of the receipt of a paper enrollment request, the MA organization must provide the beneficiary with a written notice that acknowledges receipt of the complete enrollment request, and indicates that the enrollment will take effect on January 1 of the following year (refer to Exhibits 4, 4a, 4b and 4c for model notices).

- For AEP enrollment requests received prior to the start of the AEP, the MA organization must submit all transactions to CMS systems (MARx) on the first day of the AEP with an "application date" of the same date. For example, unsolicited AEP paper enrollment requests received October 1 through October 14 must be submitted on October 15th with an "application date" of October 15th of the current year in the appropriate data field on the enrollment transaction. If a beneficiary has submitted more than one AEP paper enrollment request prior to the start of the AEP, the beneficiary will be enrolled in a plan based on the first application that is processed.

- Once the MA organization receives a MARx TRR from CMS indicating whether the individual's enrollment has been accepted or rejected, it must meet the remainder of the requirements (e.g., sending a notice of the acceptance or rejection of the enrollment within 10 calendar days following receipt of the TRR from CMS) provided in §40.4.2.

Note: If organizations receive incomplete unsolicited AEP paper enrollment requests prior to the start of the AEP, they must follow existing guidance for working with beneficiaries to complete the applications (refer to §40.2.2).

Again, this policy applies only to the receipt of unsolicited paper enrollment forms prior to the beginning of the AEP. To help ensure a successful AEP season, it is imperative that organizations follow these steps and submit valid enrollment transactions promptly as directed.

40.1 - Format of Enrollment Requests

MA organizations must have, at minimum, a paper enrollment form process (as described in this chapter and approved through the CMS marketing material review process described in the Medicare Marketing Guidelines) available for potential enrollees to elect enrollment in an MA plan. MA organizations must also process auto- and facilitated enrollment requests into MA-PD plans as described in §40.1.5 of this section.

MA organizations have the option to accept enrollment requests as described in §§40.1.2, 40.1.3, 40.1.4 and 40.1.5 below.

40.1.1 - Enrollment Request Mechanisms

The MA organization must use an enrollment mechanism that complies with CMS' guidelines in format and content.

Specific model enrollment forms have been developed for each plan type as follows:

Exhibit 1 - MA coordinated care plans
Exhibit 1b - MSA plans
Exhibit 1c - PFFS plans

Organizations should utilize the model appropriate to the plan type for all enrollment request mechanisms to ensure all required elements are included. Organizations may develop their own materials using these models subject to the CMS review and approval of plan marketing materials process. CMS has also developed a model short enrollment mechanism (Exhibit 3) and a model plan selection mechanism (Exhibit 3a) to allow for enrollment requests into another plan (PBP) offered by the same parent organization, as well as a model EGHP enrollment mechanism (Exhibit 2). Organizations must ensure that the short form contains all elements required for enrollment requests into a particular plan type. As a result, a short enrollment form or a model plan selection form may be used only for enrollment requests into another plan of the same type (i.e., HMO to HMO, PPO to PPO, or PFFS to PFFS). For the purpose of determining the appropriate use of the short enrollment form or model plan selection form, CMS defines parent organization as the contract numbers (H#) and legal entities that are owned and operated by a single organization in a single state.

Enrollment mechanisms must include the applicant's acknowledgement of the following:

- Understanding of the requirement to continue to keep Medicare Part A and B
- Agreement to abide by the MA plan's membership rules, as outlined in member materials;
- Consent to the disclosure and exchange of information necessary for the operation of the MA program;
- Understanding that he/she can be enrolled in only one Medicare health plan and that enrollment in the MA plan automatically disenrolls him/her from any other Medicare health plan and prescription drug plan. Note: The model PFFS and MSA enrollment mechanisms provide language as appropriate; and
- Understanding of the right to appeal service and payment denials made by the organization.

Please refer to Appendix 2 for a complete listing of required elements that must be included on enrollment mechanisms and Exhibits 1 – 3a for complete information on the required statements.

The plan premium is not required on the enrollment mechanism unless it is part of the plan name. Organizations may include the premium on the enrollment mechanism if they choose to do so, but they must do so consistently for all PBPs listed on the enrollment mechanism.

Special Needs Plans (SNPs) must include elements on the enrollment mechanism that correspond to the special needs focus of the particular SNP.

Medical Savings Plans (MSA) must include elements on the enrollment form as provided in Exhibit 1b.

No enrollment form or other enrollment request mechanism may include a question regarding binding arbitration, whether the individual receives hospice coverage (except MSA plans) or any other health screening information, with the exception of questions regarding ESRD status and

nursing home status (some additional exceptions apply for SNPs; please refer to §40.2, item "D" of this chapter).

Refer to §60.9 for requirements regarding retention of enrollment request mechanisms.

40.1.2 – Electronic Enrollment

MA organizations may develop and offer electronic enrollment mechanisms made available via a plan owned electronic device or secure internet website.

The following guidelines, in addition to all other program requirements, apply to electronic enrollment mechanisms:

- *Submit all materials, web pages, and images (e.g. screen shots) related to the electronic enrollment process for CMS approval following the established process for the review and approval of marketing materials and other enrollment request mechanisms.*
- *Provide beneficiaries with all the information required by CMS' marketing guidelines for the MA program.*
- *At a minimum, comply with CMS' data security policies (found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Information-Security-Library.html on the web). The MA organization may also include additional security provisions to ensure the appropriate handling of protected health information (PHI).*
- *Advise each individual at the beginning of the electronic enrollment process that he/she is completing an actual enrollment request to the MA organization.*
- *Capture the same data as required on the model enrollment form (see Exhibit 1 and Appendix 2). For enrollment requests from one plan to another plan within the same parent organization, the data required on the model short enrollment form are sufficient, provided the plan can verify that the individual is currently enrolled in the parent organization at the time the individual submits the enrollment request.*
- *As part of any electronic enrollment process, include a clear and distinct step that requires the applicant to activate an "Enroll Now," or "I Agree," type of button or tool. By taking this affirmative step, the individual indicates his/her intent to enroll. It must also be made clear to the applicant that, by taking this action, he or she agrees to the release and authorization language as provided on the model enrollment form (see Exhibit 1), and attests to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information.*
- *The mechanism must capture an accurate time/date stamp at the time the applicant activates the step in the previous bullet (i.e. "Enroll Now/I Agree" button or tool). The organization will use this data to establish the application date for the enrollment request.* ***This time stamp also marks the start of the seven day timeframe for processing the enrollment request, as it is at this time that the enrollment request is considered by CMS to be received by the MA organization.***
- *If a legal representative is completing this enrollment request, s/he must attest that s/he has such authority to make the enrollment request and that proof of this authority is available upon request by the MA organization or CMS.*

- *Inform the individual of the effects of completing the electronic enrollment, including that s/he will be enrolled (if approved by CMS), and that s/he will receive notice (of acceptance or denial) following submission of the enrollment to CMS.*
- *Include a tracking mechanism (e.g., a confirmation number) to provide the individual with evidence that the MA organization has received the electronic enrollment request.*
- *Optionally, may request or collect premium payment or other payment information, such as a bank account number or credit card numbers.*
- *Maintain electronic records that are securely stored and readily reproducible for the period required in §60.9 of this chapter. The MA organization's record of the enrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member and/or CMS. A data extract file alone is not acceptable.*
- *The option of electronic enrollment, other than the CMS Online Enrollment Center described below, is limited to requests submitted via an electronic device or software (including web pages) owned by the MA organization. For example, electronic enrollment via the MA organization's website is permissible, but electronic enrollment via other means, such as a broker website or non-plan owned electronic mechanism, is not permitted.*

Medicare Online Enrollment Center
In addition to the process described above, CMS offers an online enrollment center (OEC) through the www.medicare.gov website and the 1-800-MEDICARE Call Center for enrollment into Medicare Advantage plans (except for MSA) and Medicare prescription drug plans. The date and time "stamped" by the Medicare Online Enrollment Center will serve as the application date for purposes of determining the election period and enrollment effective date. MA organizations [PDP sponsors] must promptly retrieve enrollment requests from the OEC and should check for requests at least daily. ~~***40.1.2 - Enrollment via the Internet***~~

~~MA organizations may develop and offer enrollment requests into an MA plan via the organization's secure internet web site. The following guidelines must be applied in addition to all other program requirements:~~

- ~~Submit all materials and web pages related to the online enrollment process for CMS approval following the established process for the review and approval of marketing materials and other enrollment request mechanisms.~~
- ~~Provide beneficiaries with all the information required by CMS' marketing guidelines for the MA program.~~
- ~~At a minimum, comply with CMS' internet security policies (found at: http://www.cms.hhs.gov/informationsecurity/ on the web). The MA organization may also include additional security provisions.~~
- ~~Advise each individual at the beginning of the online enrollment process that he/she is sending an actual enrollment request to the MA organization.~~
- ~~Capture the same data as required on the model enrollment form (see Exhibit 1 and Appendix 2; enrollment requests from one PBP to another within the same parent organization are eligible to use the short enrollment form).~~
- ~~As part of the online enrollment process include a separate screen or page that includes an "Enroll Now," or "I Agree," type of button, that the individual must click on to indicate his/her intent to enroll and agreement to the release and authorization language, as provided on the model enrollment form (see Exhibit 1), and attest to the truthfulness of the data~~

~~provided. The process must also remind the individual of the penalty for providing false information.~~

- ~~If a legal representative is completing this enrollment request mechanism, s/he must attest that s/he has such authority to make the enrollment request and that proof of this authority is available upon request by the MA organization or CMS.~~
- ~~Inform the individual of the consequences of completing the internet enrollment, including that s/he will be enrolled (if approved by CMS), and that s/he will receive notice (of acceptance or denial) following submission of the enrollment to CMS~~
- ~~Include a tracking mechanism to provide the individual with evidence that the internet enrollment request was received (e.g. a confirmation number).~~
- ~~Optionally, may request or collect premium payment or other payment information, such as a bank account number or credit card numbers.~~
- ~~Maintain electronic records that are securely stored and readily reproducible for the period required in §60.8 of this chapter. The organization's record of the enrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member and/or CMS. A data extract file alone is not acceptable.~~
- ~~The option of online enrollment, other than the CMS Online Enrollment Center described below, is limited to requests submitted via the MA organization's website. Online enrollment via other means, such as a broker website, is not permitted.~~

~~An organization may allow members to complete an online version of the "short form" for PBP changes within the same parent organization, as long as the plan can verify that the individual is currently enrolled in the parent organization at the time the individual submits the application. For example, the plan may require the individual's active plan membership ID number in order to log in to the plan's system prior to allowing the PBP change. The "short form" may not be used for new enrollments of individuals not already within the same parent organization.~~

~~Medicare Online Enrollment Center~~

~~In addition to the process described above, CMS offers an on-line enrollment center (OEC) through the www.medicare.gov web site and the 1-800-MEDICARE Call Center for enrollment into Medicare Advantage plans (except for MSA) and Medicare prescription drug plans. The date and time "stamped" by the Medicare Online Enrollment Center will serve as the application date for purposes of determining the election period and enrollment effective date. MA organizations must promptly retrieve enrollment requests from the OEC and should check for requests at least daily.~~

40.1.3 - Enrollment via Telephone

MA organizations may accept requests for enrollment into their MA plans via an incoming (in-bound) telephone call to a plan representative or agent. The following guidelines must be followed, in addition to all other applicable program requirements:

- Enrollment requests may be accepted only during an incoming (or in-bound) telephone call from a beneficiary. This includes inbound calls to an incorrect department or extension transferred internally.
- The MA organization must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his/her authorized representative and that the plan

representative, sales agent or broker is not physically present with the beneficiary or present on the phone at the time of the request.

- Individuals must be advised that they are completing an enrollment request.
- Each telephonic enrollment request must be recorded (audio) and include a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as described in Appendix 2), and a verbal attestation of the intent to enroll. If the request is made by someone other than the beneficiary, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information. All telephonic enrollment recordings must be reproducible and maintained as provided in section §60.8.
- Include a tracking mechanism to provide the individual with evidence that the telephonic enrollment request was received (e.g. a confirmation number).
- Collection of financial information (e.g. a credit card or bank account number) is prohibited at any time during the call.
- A notice of acknowledgement and other required information must be provided to the individual as described in §40.4.1.
- Telephonic enrollment requests into a plan offered by the same parent organization may be based on the model short enrollment form (Exhibit 3) or the model plan selection form (Exhibit 3a) instead of the comprehensive individual enrollment form.

The MA organization must ensure that all MA eligibility and enrollment requirements provided in this chapter are met. Scripts for completing an enrollment request in this manner must be developed by the MA organization. The scripts must contain the required elements for completing an enrollment request as described in Appendix 2, and must receive CMS approval in accordance with CMS Marketing Guidelines before use.

40.1.4 - Seamless Conversion Enrollment Option for Newly Medicare Advantage Eligible Individuals

MA organizations may develop processes to provide seamless enrollment in an MA plan for newly Medicare Advantage eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as commercial or Medicaid plans) at the time of their conversion to Medicare. CMS will review an organization's proposal and must approve it before use. MA organizations must send proposals to the appropriate Regional Office account manager and must meet the following conditions.

- A description of the MA organization's process to identify individuals currently enrolled in a health plan offered by the organization. Such process must be able to identify these individuals no later than 90 days prior to the date of initial Medicare eligibility (the conversion date) and must include individuals whose eligibility is based on disability as well as age.
- A description of the outreach activity associated with the seamless conversion process including a written notice provided to each individual at least 60 days prior to the date of conversion. The notice must include clear information instructing the individual on how to opt-out, or decline, the seamless conversion enrollment.
- Acknowledgement that the MA organization will send the appropriate enrollment transaction to CMS at the same time that it sends the written notice (see previous bullet point); i.e., at least 60 days prior to the conversion date.

- The process to opt-out or decline the seamless conversion enrollment must include the opportunity to contact the MA organization either in writing or by telephone to a toll-free number. The MA organization is prohibited from discouraging declination. The process must allow for opt-out requests to be accepted up to and including the day preceding the enrollment effective date. The organization will submit opt-out requests to CMS as enrollment cancellations.
- Enrollment transactions submitted to CMS for these cases must always use the first day of an individual's ICEP as the application date in the transaction record. Doing so ensures that any subsequent action taken by the individual will take precedence in systems processing. In addition, the enrollment effective date must always be the date of the individual's first entitlement to **both** Medicare Part A and Part B.
- Plans must have beneficiary information, including HICN, date-of-birth and sex in order to process seamless conversion enrollments.

40.1.5 - Auto- and Facilitated Enrollment

CMS requires that MA organizations offering both MA-PD and MA-only plans have a process for auto- and facilitated enrollment. All LIS eligible individuals who elect an MA plan without Medicare prescription drug benefits ("MA-only plan") will be auto- or facilitated enrolled into an MA-PD plan in the same organization or into a PDP offered by the same organization, unless the individual declines the enrollment. The MA organization's auto- and facilitated enrollment processes will occur monthly. As noted in the preamble to the final regulation for Part D (Federal Register/Vol. 70, No. 18, January 28, 2005), the legal authority for both auto- and facilitated enrollment processes is technically termed "facilitated" enrollment, since auto-enrollment is limited to PDPs. However, the term "auto-enrollment" is used here to denote the process that applies to full-benefit dual eligible individuals, and "facilitated enrollment" to others with LIS.

CMS has safeguards in place to prevent existing MA and cost plan enrollees from being auto- or facilitated enrolled by CMS into a PDP. However, there may be instances in which a beneficiary's request to enroll into an MA plan will not yet be reflected in CMS systems at the point in time when CMS processes auto- or facilitated PDP enrollments. In these cases, the beneficiary will receive a notice from CMS informing him/her that s/he has been enrolled into a PDP. However, once the beneficiary's request to enroll into the MA plan is processed by CMS, it will prevail over the previously processed auto- or facilitated PDP enrollment submitted by CMS.

Please note this section does not apply to MA organizations that offer only MA-PD plans, as all their enrollees already have Part D coverage. Nor does it apply to PFFS plans offered by organizations that do not offer <u>any</u> MA-PD plans (these beneficiaries are included in the standard CMS auto/facilitated enrollment process into PDPs), nor to MA organizations in the U.S. territories, including Puerto Rico, or to employer sponsored MA plans.

Starting January 1, 2010, CMS implemented the Limited Income Newly Eligible Transition (Limited Income NET) demonstration, which modified its procedures for auto/facilitating enrollment of LIS beneficiaries into PDPs for those who have retroactive enrollment effective dates. That demonstration does not impact the auto/facilitated requirements for MA organizations as specified in this section, except for MA-PFFS plans that autoenroll new full benefit dual eligible enrollees into a PDP owned by the same organization (see §40.1.5, item B as well as Exhibit 27A).

A. Populations

1. Auto-Enrollment

Full-benefit dual eligibles in MA-only plans will be auto-enrolled by the MA organization into an MA-PD plan. Full-benefit dual eligible individuals are defined as those eligible for comprehensive Title XIX Medicaid benefits as well as eligible for Medicare Part D. This includes those who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare cost-sharing (sometimes known as QMB-plus or SLMB-plus). Please note that full-benefit dual eligible individuals do not include those eligible *only* for Medicaid payment of Medicare cost-sharing (i.e. QMB-only, SLMB-only, or QI). In Part D, these distinctions are key to distinguishing full-benefit dual eligibles, who need to be auto-enrolled, from other types of dual eligibles, who need to be facilitated enrolled.

Full-benefit dual eligible individuals to be auto-enrolled include those who are full-benefit dual eligible upon initial enrollment into an MA-only plan, as well as existing Medicare enrollees of an MA-only plan who become newly Medicaid eligible. This includes full-benefit dual eligible MA-only enrollees who reside in the 50 states or the District of Columbia.

This excludes full-benefit dual eligibles who:

- Live in any of the five U.S. territories;
- Live in another country;
- Are individuals for whom an employer or union is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored MA-only plan, including MA-only "800 series" plans.
- Are inmates in a correctional facility; or
- Have opted out of auto-enrollment into Part D benefits
- [For MA-PFFS only] Are already enrolled in a stand-alone Prescription Drug Plan

2. Facilitated enrollment

Other LIS eligibles are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e. only eligible for Medicaid payment of Medicare premiums and/or cost-sharing); SSI-only (Medicare and Supplemental Security Income [SSI], but no Medicaid); or those who apply for LIS at the Social Security Administration (SSA) or a State Medicaid Agency and are determined eligible for LIS. This includes those who apply and are determined eligible for either the full or partial level of the LIS.

Other LIS eligible individuals to be facilitated enrolled include those who are Other LIS eligible upon initial enrollment into an MA-only plan, as well as existing Medicare enrollees of an MA-only plan who become newly Other LIS eligible. This includes Other LIS eligible MA-only enrollees who reside in the 50 states or the District of Columbia.

This excludes Other LIS eligible individuals who:

- Live in any of the five U.S. territories,
- Live in another country,
- Are individuals for whom the employer or union is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored MA-only plan, including MA-only "800 series" plans,

- Are inmates in a correctional facility, or
- Have opted out of facilitated enrollment into the Part D benefit.
- [For MA-PFFS only] Are already enrolled in a stand-alone Prescription Drug Plan

B. Auto/Facilitated Enrollment Process

The procedure for auto/facilitated enrollment is as follows:

1. The MA organization will identify full-benefit dual eligibles to be auto-enrolled, and Other LIS eligibles to be facilitated enrolled. Please see subsection C for details on how to distinguish the two populations.

    a. Auto/facilitated enrollment specifically excludes individuals in employer-sponsored MA-only plans, including "800 series" plans, and individuals with Retiree Drug Subsidy (RDS).

    b. For PFFS plans, the organization must exclude individuals who are already enrolled in a stand-alone PDP. The organization may submit a Batch Eligibility Query (BEQ) transaction or access the MARx online query (M232 screen) to determine whether individuals are enrolled in a stand-alone PDP.

2. The MA organization will then identify MA-PD plans in the same service area, and in the same MA organization, with the lowest combined Part C and Part D premium amount. If more than one MA-PD plan have the same lowest premium amount, auto-enrollment must be random among the available MA-PD plans. The selection of MA-PD plan is without regard to the Part C cost-sharing. The only exception to this is when the MA-PD plan is a high-deductible plan, unless the high-deductible plan is the only MA-PD plan offered in the area. Please note that the Part D premium is the dollar amount equaling the premium charged to a beneficiary with a 100 percent premium subsidy.

    If an MA Special Needs Plan (SNP) meets these criteria, the MA organization must ensure that the individual meets the eligibility criteria for the SNP (e.g. type of dual eligible, type of chronic condition, or institutionalized). Please note the "MA full dual file" uses LIS deemed reason code to identify full duals, meaning they were full dual in at least one month in the past year; it cannot be used by MA organizations to confirm dual status in the current month. If the MA SNP does not meet the criteria of lowest combined Part C and D premium (with the Part D premium equaling the premium charged to a beneficiary with a 100 percent premium subsidy), the MA organization may not auto-enroll full benefit dual eligibles into it, even if it is a dual eligible SNP.

    Organizations offering both an MA-PD PFFS plan and a stand-alone PDP in the same region with a basic benefit and a premium at or below the low-income premium subsidy amount for that region may auto/facilitate enrollment into either the MA-PD PFFS plan or the PDP, but must apply this policy consistently for all PFFS plans offered by the organization. CMS will conduct auto/facilitated enrollment of LIS individuals enrolled in MA-only PFFS plans where the organization does not offer an MA-PD PFFS plan, even if they also offer a stand-alone PDP.

3. Within 10 calendar days of identifying an individual as needing auto/facilitated enrollment, the MA organization sends an auto/facilitated enrollment notice to the beneficiary (see Exhibits 27, 27A, 28 and 28a).

4. If the person does not respond or opt-out by the deadline below, submit a Code 61 transaction (PBP change) for the auto/facilitated enrollment into the MA-PD plan and include the appropriate effective date within the timelines specified below (see subsection C). The new MA-PD plan will be notified of the auto/facilitated enrollment via a transaction reply.

    - Auto-enrollment – within 10 calendar days of sending notice
    - Facilitated enrollment – by last day before effective date of facilitated enrollment

C. Effective Date of Auto/Facilitated Enrollments

1. Auto-Enrollment

The effective date of auto-enrollment is retroactive to the first day of the month the individual first became a full-benefit dual eligible, or January 1, 2006, whichever is later. For individuals who are full-benefit dual eligible upon enrollment into an MA-only plan, the effective date would be retroactive to the effective date of enrollment in the MA-only plan. For existing MA-only Medicare enrollees who subsequently become Medicaid eligible, the effective date is retroactive to the first day of the month the person became Medicaid eligible. In no case will the effective date of auto-enrollment precede the date that the individual became an enrollee of the MA organization.

For MA-PFFS plans that elect to auto-enroll a full-benefit dual eligible beneficiary into a PDP offered by the same organization, the effective date will be prospective, i.e., the first day of the second month after the enrollee is identified as a new full benefit dual eligible. This is because CMS implemented the Limited Income NET demonstration in January, 2010, in which a single contractor addresses all retroactive periods of PDP auto-enrollment. The MA-PFFS may not submit an election on behalf of a beneficiary into the Limited Income NET demonstration contractor. To ensure the beneficiary is aware s/he can request retroactive coverage from the demonstration contractor, Exhibit 27a includes instructions on how to do so.

There is nothing that prohibits a full-benefit dual eligible from initially electing an MA-only plan. To ensure they understand the consequences of doing so, marketing material and the acknowledgement letter emphasize that prescription drugs are not covered.

2. Facilitated Enrollment

The effective date of facilitated enrollment for all Other LIS eligible members is the first day of the second month after the person is identified as qualifying for facilitated enrollment. For example, if the plan is notified in August 2010 that an existing member of an MA-only plan has become LIS eligible, the effective date is October 1, 2010.

The MA organization may move up the effective date of a facilitated enrollment by a month if an Other LIS beneficiary requests this in a timely fashion, i.e. before start of earlier month. If the person is a full or partial dual eligible, the SEP under §30.4.4 #5 should be used. If the person is a non-dual LIS eligible, the SEP in §30.4.4 #12 is available.

> **Example:** The MA organization facilitates enrollment of an Other LIS eligible in May, 2010, effective July 1, 2010. The beneficiary receives the facilitated enrollment by the last

day in May, and requests the MA organization makes the facilitated enrollment effective June 1. The MA organization submits an enrollment transaction to do so.

3. Distinguishing Between Full-Benefit Dual Eligible and Other LIS Individuals

MA organizations need to distinguish full benefit dual eligibles from others with LIS for purposes of setting the effective date. The first step is to identify all LIS eligibles in the MA-only plan. In the past, CMS did not transmit a data element to plans that could be used to distinguish full-benefit dual eligibles from other LIS. As a result, CMS sends a monthly "Auto Assignment Full Dual Notification File" (for file format and technical specifications, please see section 8.1 of the Plan Communications User Guide, on the CMS website at http://www.cms.hhs.gov/mmahelp/. This file identifies full-benefit dual eligibles.

However, starting December, 2010, the monthly membership report (MMR) will include a new field (Medicaid dual status code) that will provide the dual status code of the enrollee, if that enrollee has Medicaid status. The new field will be aligned with the already-existing Field 40 (Current Medicaid Status). If Field 40 indicates that the enrollee has Medicaid status, Field 85 will provide the dual status code for that enrollee. Field 40 indicates that an enrollee is Medicaid when that enrollee has a Medicaid period reported to CMS for either the month prior to payment or two months prior to payment. Please note that Field 40 and, thus the new field, are not related to payment, but are provided for purposes of benefits coordination and bidding. The new field will be coded as follows:

The valid values when Field 40 = 1 are:

01 = Eligible is entitled to Medicare- QMB only
02 = Eligible is entitled to Medicare- QMB AND Medicaid coverage
03 = Eligible is entitled to Medicare- SLMB only
04 = Eligible is entitled to Medicare- SLMB AND Medicaid coverage
05 = Eligible is entitled to Medicare- QDWI
06 = Eligible is entitled to Medicare- Qualifying individuals
08 = Eligible is entitled to Medicare- Other Dual Eligibles (Non QMB, SLMB,QDWI or QI) with Medicaid coverage
09 = Eligible is entitled to Medicare- Other Dual Eligibles but without Medicaid coverage
99=Unknown

The valid value when Field 40 = 0 is:

00 = No Medicaid Status

The valid value when Field 40 is blank is: Blank

Full-benefit dual eligible beneficiaries are represented by dual status codes 02, 04, and 08.

To ensure a sufficient period of transition, CMS will continue to send the Auto Assignment Full Dual Notification File to identify the subset of the LIS enrollees in the MA-only plan who are full-benefit dual eligibles. Plans may begin using the MMR instead, but starting August, 2011, plans will be required to use the MMR as CMS will discontinue transmission of the Auto Assignment Full Dual Notification File.

To determine the auto-enrollment effective date, identify the LIS copay start date data provided on other files (i.e., Transaction Reply Report or monthly LIS history report). MA-PFFS plans

that elect to auto/facilitate enroll new LIS beneficiaries into a PDP offered by the same organization do not need to distinguish between full-benefit dual eligible enrollees and others with LIS because the effective date will always be prospective.

The remaining LIS eligibles in the MA-only plan qualify for facilitated enrollment, and the effective date should be set as noted in item 2 above.

D. Notice

The MA organization will notify the beneficiary in writing that she/he will be enrolled in the given MA-PD plan on the specified effective date. The notice must be sent within 10 calendar days of identifying the individual as qualifying for auto/facilitated enrollment. The notice will inform the beneficiary that they may choose another Part D plan (either another MA-PD plan or Original Medicare with a PDP) or opt out of auto/facilitated enrollment into the Part D benefit. If the beneficiary does not opt out, or choose another Part D plan within the specified deadline, the person's silence will be deemed to be an election of the auto/facilitated enrollment and it will take effect on the effective date. These individuals will also be informed they have a Special Enrollment Period (SEP) that permits them to change Part D plans, even after the auto/facilitated enrollment takes effect.

1. Auto-Enrollment

Please use the model notice language in Exhibit 27. For MA-PFFS auto-enrolling into a PDP, please use Exhibit 27a. The deadline for responding is 10 calendar days from when the notice is sent. The SEP available is continuous (i.e. full-benefit dual eligibles may change plans in any month).

2. Facilitated enrollment

Please use the model notice language in Exhibit 28. For MA-PFFS auto-enrolling into a PDP, please use Exhibit 28a. The deadline for responding is the last day before the facilitated enrollment effective date. The SEP available is continuous.

E. Opt-Out

Full-benefit dual eligible and Other LIS individuals may opt-out, or affirmatively decline, the Part D benefit. Beneficiaries may opt-out verbally or in writing. For an MA-only plan enrollee, this primarily means declining auto/facilitated enrollment into an MA-PD plan in the same organization and maintaining enrollment in the MA-only plan. MA organization may check the common User Interface to see if the individual has previously opted out; if so, the person should not be auto/facilitated enrolled. Once a beneficiary has opted out, the MA organization should document this and not include him/her in future auto/facilitated enrollment processing.

The MA plan should counsel the individual to ensure they understand the implications of their request to decline, and should confirm this in writing (see Exhibit 29) within 10 calendar days of the individual's request to opt-out. If a beneficiary opts out of auto/facilitated enrollment by the deadline in the auto/facilitated notice, do not submit an enrollment transaction that would move them to an MA-PD plan. This will have the effect of leaving him/her in the MA-only plan.

If the individual opts-out after the Code 61 transaction has been submitted, the effective date of returning to the MA-only plan is normally prospective, i.e. first day of the following month. However, through the 15th of the month after the month in which the notice was sent, at a full-dual eligible beneficiary's request, the MA organization may restore the person to the MA-only plan retroactive to the auto-enrollment effective date. This is accomplished by submitting a Code 61 transaction with the same effective date, and setting the opt-out flag as noted below.

Individuals who want to opt-out of auto/facilitated enrollment into an MA-PD plan must do so with their MA organization, not through 1-800-MEDICARE. This differs from the procedure for individuals who want to opt-out of auto/facilitated enrollment into a stand-alone PDP. If a 61 transaction has already been submitted to move the person to the MA-PD plan, the MA organization sends another 61 transaction (to move the person back to the MA-only plan), setting the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment) . If it has not, submit just the opt out indicator on a ~~74~~ 79 transaction.

An individual who opts out does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto/facilitated enrollment processes. To obtain Part D benefits, the beneficiary simply makes a voluntary request to enroll into a plan that offers Part D benefits.

F. Special Procedures for Individuals With Employer Coverage

When the individual's employer or union-sponsored enrollment, including in "800 series" plans, or Retirement Drug Subsidy (RDS) status is known, the MA organization shall exclude the individual from auto/facilitated enrollment. It is possible the MA organization will not be aware an individual has RDS until they submit a Code 61 transaction to auto/facilitate his/her enrollment. As with all enrollment transactions for individuals with RDS, MARx will enforce a two-step process, initially rejecting the transaction. The MA organization must follow normal procedures of confirming with the beneficiary that she/he wants to be enrolled in the Part D benefit and, if confirmed, resubmit the transaction with the employer subsidy override.
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G. Information Provided to Auto/Facilitated Enrolled Beneficiaries

The MA-PD plan into which the beneficiary has been auto/facilitated enrolled must send a modified version of the pre- and post-enrollment materials required to be provided to new enrollees. If the effective date is retroactive into the previous calendar year, only send the current year's version of the documents below.

Prior to effective date, the MA-PD plan must send:

- The information required in §40.4.1, and

- A Summary of Benefits (those who are auto/facilitated enrolled still need to make a decision whether to stay with the plan into which they have been auto/facilitated enrolled or change to another one that better meets their needs). Providing the Summary of Benefits, which is considered marketing material normally provided prior to making an enrollment request, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.

After the effective date of coverage:

- The guidance in §40.4.2 applies, including guidance on what to do if the MA-PD plan is not notified early enough of an auto/facilitated enrollment to meet the timelines in §40.4.1 on materials required to be provided prior to the effective date.

H. Summary of Differences Between Auto- and Facilitated Enrollment Processes

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Steps	• Identify full dual eligibles in MA-only plan who need to be enrolled into MA-PD plan • Send notice to beneficiary within 10 calendar days of identifying need for person to be auto-enrolled • If no answer or person does not opt out within 10 calendar days, submit 61 transaction to move to MA-PD plan	• Identify non-full dual LIS beneficiaries in MA-only plan who need to be enrolled into MA-PD plan • Send notice to beneficiary within 10 calendar days of identifying need for person to be facilitated enrolled • If no answer or person does not opt out by last day before effective date of facilitated enrollment, submit 61 transaction to move to MA-PD plan
Who needs to be moved	• Full dual who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became Medicaid eligible and is thus newly full dual	• Non-full dual with LIS who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became LIS-eligible
Who does not need to be moved	• Those who have already opted out • Those with RDS • Those in "800 series" employer sponsored plans • Those in employer sponsored plans (other than "800 series" plans)	• Those who have already opted out • Those with RDS • Those in "800 series" employer sponsored group plans • Those in employer sponsored plans (other than "800 series" plans)
Data to identify those in MA-only plan who need to be moved to MA-	Monthly MA full dual file or on MMR with dual status code 02, 04, or 08	LIS data (TRR or monthly LIS history report): • Premium subsidy = 25%, 50%,

PD plan		75% OR • Premium subsidy = 100 *and* LIS copay = 4 (15%) OR • Premium subsidy = 100 *and* LIS copay = 1, 2, or 3, *and* person is not on MA full dual file or on MMR with dual status code 02, 04, or 08
Plan Into Which Beneficiary Should be Enrolled	MA-PD plan with the lowest combined Part C and D premium	MA-PD plan with the lowest combined Part C and D premium
Notice to send	Exhibit 27 (27a if applicable)	Exhibit 28 (28a if applicable)
Effective date	• First day of month person qualified for LIS (will be retroactive) • Cannot be prior to start of enrollment in the MA-only plan	• First day of second month after person identified as needing enrollment • Cannot be prior to start of enrollment in the MA-only plan
Opt out	• Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 29) • If submitting 61 transaction to move beneficiary back to MA-only, set Opt-Out flag to Y (field 38)	• Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 29) • If submitting 61 transaction to move beneficiary back to MA-only, set Opt-Out flag to Y (field 38)

Data on Transaction	**Auto-Enrollment of Full Duals**	**Facilitated Enrollment of Other LIS**
Application date	First day of month prior to enrollment effective date OR day after current application date on MA-only plan enrollment, whichever is later.	First day of month prior to effective date of the enrollment
Election type Code	Z = MA auto-enrollment period*	U = Dual/LIS Special Enrollment Period
Enrollment Source Code	E (MA-submitted auto-enrollment)*	F (MA-submitted facilitated enrollment)

* Use of the enrollment period of “Z” and enrollment source code of “E” permits these 61 transactions for retroactive auto-enrollments to bypass normal MARx suspension of processing for retroactive effective dates (i.e. they will process immediately).

40.1.6 – Additional Enrollment Request Mechanisms for Employer/Union Sponsored Coverage

MA organizations may choose to accept voluntary enrollment requests directly from the employer or unions who sponsor MA coverage for its members in any of the enrollment mechanisms described in this guidance (except auto or facilitated enrollment). In addition, the MA organization may also accept enrollment requests using either the optional enrollment request mechanism or group enrollment process described in this section.

It is the MA organization's responsibility to ensure that all applicable MA enrollment requirements are met, regardless of the process utilized, as required by CMS. In any case, the enrollment requests provided to the MA organization by the employer or union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan.

For enrollments processed using the SEP EGHP, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of enrollment into the employer or union group-sponsored plan. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the organization receives the request.

40.1.6.1 - Group Enrollment Mechanism

CMS will allow an MA organization to accept enrollment requests into an employer or union sponsored MA plan using a group enrollment process in which beneficiaries enroll in an employer or union sponsored MA plan. Beneficiaries participate in this process through advance notification that provides each individual with all the information necessary to make an informed choice. Furthermore, the process must provide CMS with any information the employer/union has on other insurance coverage for the purposes of coordination of benefits. It is the MA organization's responsibility to ensure the group enrollment process meets all applicable MA enrollment requirements. MA organizations must ensure that any contracts and other arrangements and agreements with employers and unions intending to use the group enrollment process make these requirements clear.

The group enrollment process must include providing the following information to each beneficiary as follows:

- Beneficiaries participate in the group enrollment mechanism by receiving an advance notice that the employer/union intends to enroll them for a prospective coverage effective date in an MA plan that the employer/union is sponsoring; and
- Clear instruction that the beneficiary may affirmatively opt out of such enrollment; explaining the process to opt-out; and any consequences to employer or union benefits opting out would bring; and
- This notice must be provided by the MA organization, or the employer or union acting on its behalf, not less than 21 calendar days prior to the effective date of the beneficiary's enrollment in the employer/union sponsored MA plan; and
- Additionally, the information provided to each beneficiary must include a Summary of Benefits offered under the employer/union sponsored MA plan, as well as an explanation of how to get more information about the MA plan, and an explanation on how to contact Medicare for information on other Medicare health plan options that might be available to the beneficiary; and
- Each individual must also receive in the group enrollment notice materials the information contained in Exhibit 2 under the heading "Please Read & Sign Below."

The organization must ensure all of the above requirements are met prior to submission of the enrollment transactions to CMS. For enrollments processed using the SEP EGHP, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems.

The employer or union must provide in the group enrollment file(s) all the information required for the MA organization to submit a complete enrollment request transaction to CMS, including permanent residence information (refer to Appendix 2 of this chapter for a complete list of the required data elements and any other relevant CMS systems guidance). Records must be maintained as outlined in §60.9 of this chapter.

40.1.6.2 - Optional Mechanism For MA Group-sponsored plan Enrollment

This enrollment request mechanism is optional for MA organizations and may not be required. Therefore, MA organizations may specify the employers or unions, if any, from which they will accept this enrollment request format. It is the MA organization's responsibility to ensure that the process it uses, as well as the process used by the employer or union, meets the following requirements:

The MA organization must inform its Regional Office Account Manager of its intent to use this mechanism and identify the employer group(s) or union(s) for which it will be accepting enrollments made in this manner.

The enrollment information (i.e., the electronic file) submitted to the MA organization by an employer or union (or TPA) must accurately reflect the employer's or union's record of the election of coverage made by each individual according to the processes the employer or union has in place, and may be accepted without a paper MA enrollment request form.

Sales package minimum information requirements are not changed by using this option. These include, but are not limited to, providing the applicable rules of the MA organization. Each individual's enrollment request must clearly denote his/her agreement to abide by the MA organization rules, certify his/her receipt of required disclosure information and include authorization by the beneficiary for the disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (and its designees) and the MA organization. The requirements for all other information provided to enrollees, both pre- and post-enrollment, are unchanged by this option and must be satisfied.

The enrollment request transaction must include all the data necessary for the MA organization to determine each individual's eligibility to make an enrollment request as described in §20 of this chapter of the MMCM. Agreements with employer groups or unions should identify required data elements. A detailed list of these elements is provided as Appendix 2.

This alternate enrollment request mechanism is used in place of paper MA enrollment request forms and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the application date of enrollments processed using the SEP EGHP will be the first day of the month prior to the effective date of enrollment into the employer/union sponsored plan. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the enrollment submitted by the employer or union.

Effective date calculation of voluntary enrollment requests and the collection and submission of enrollment requests to CMS will follow existing procedures.

To accept electronic records of employer or union enrollment requests, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information. (See the CMS web site at: http://www.cms.hhs.gov/informationsecurity for additional information.)

The employer's or union's record of the request to enroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the MA organization and/or CMS, as necessary, and be maintained (by the employer/union or the MA organization, as they agree) following the guidelines for MA enrollment request forms (see §60.9). Included in this requirement is the MA organization's record of information received from the employer or union.

40.1.7 - Enrollment for Beneficiaries in Qualified State Pharmaceutical Assistance Programs (SPAPs)

CMS will allow MA organizations to accept enrollment requests in an agreed-upon electronic file format from qualified SPAPs, provided the SPAP has met the following requirements:

- The SPAP must attest, as required by §40.2.1 of this guidance, that it has the authority under state law to enroll on behalf of its members.
- The SPAP must coordinate with the MA Organization to provide the required data elements for the organization to process and submit an enrollment request to CMS.
- The SPAP must provide a notice to its members in advance of submitting the requests that explains that it is enrolling on their behalf, how the enrollment works with the SPAP and how individuals can decline such enrollment.

In return, MA organizations that agree to accept mass enrollment requests from SPAPs are required to process them like any other enrollment and in accordance with notification timeframes. Additionally, the organization must ensure the SPAP has met the above requirements prior to submission of the enrollment transaction to CMS. It is important for the MA organization to work with the SPAP in the event that the organization encounters any problems processing the enrollment request in the format provided. Because the SPAP is the authorized representative of the beneficiary, the organization is responsible for following up with the SPAP if the enrollment is incomplete in any way (to obtain missing information) or if the enrollment is conditionally rejected due to the existence of employer or union sponsored drug coverage (to confirm that the individual understands the implications of enrolling in a Part D plan).

Special note for SPAP enrollment requests during the AEP - For enrollment processing purposes, the application date on the enrollment transaction submitted to CMS for the AEP must be set to October 15th. This will ensure that subsequent beneficiary-generated enrollment requests made during the AEP will supersede the SPAP enrollment in CMS systems.

40.1.8 – Re-Assignment of Certain LIS Beneficiaries

CMS has the discretion to re-assign LIS beneficiaries, including situations in which their current MA plan will terminate. CMS will announce its intent to conduct reassignment in the Call Letter. CMS will conduct the reassignment in the fall of each year, and ensure all affected LIS beneficiaries are notified. Affected MA organizations are not responsible for initiating any disenrollment transactions for reassigned beneficiaries. Gaining PDP sponsors are only responsible for responding to the CMS enrollment transaction promptly when they receive it and for providing appropriate beneficiary notices and materials, as described below.

A. Population to be Re-Assigned

CMS will reassign all current LIS enrollees in terminating MA plans. This includes non-renewing MA only plans, as well as MA-PD plans and MA PFFS plans. CMS will perform this reassignment when plan benefit packages are being non-renewed in their entirety, as well as MA plans that will continue but have service area reductions (SARs). In the case of an MA-only or MA-PD plan with a SAR, reassignment will only be performed for counties that will no longer be served by the plan in the following year).

Beneficiaries who have LIS this year and will continue to do so next year will be included in this reassignment process, regardless of whether the individual was assigned to or voluntarily enrolled in a plan. The only exception is when an LIS beneficiary in an MA-PFFS plan that does not offer drugs is concomitantly enrolled in a stand-alone PDP. In these cases the beneficiary will not be reassigned.

Reassignment is not performed for LIS beneficiaries in a non-renewing MA-only or MA-PD plan in the U.S. Territories, or in an employer-sponsored MA-only or MA-PD plan.

The actual reassignment process is typically run on a single day in mid-October. CMS will only reassign beneficiaries who meet the above criteria as of the day of the reassignment run. CMS does not subsequently "sweep" for individuals who may meet the criteria at later points in time.

B. Re-assignment Process

CMS will reassign LIS beneficiaries from a non-renewing MA plan or MA plan with a SAR to a stand-alone prescription drug plan (PDP). Beneficiaries retain the option to elect another MA plan.

CMS will attempt to reassign beneficiaries to a PDP offered by the same organization that offers the MA plan in which they are currently enrolled, wherever possible. CMS will identify PDPs that qualify to receive reassignment and are sponsored by the same parent organization (see §40.1.5 in Chapter 3 of the Medicare Prescription Drug Benefit Manual for details on PDPs to which beneficiaries will be reassigned as well as for the responsibilities of those "gaining" PDPs). If the organization has more than one such plan in that region, CMS will randomly reassign beneficiaries among those plans.

If the organization does NOT offer a qualifying PDP, CMS will randomly reassign affected beneficiaries to PDP sponsors that have at least one qualifying PDP in that region. CMS will

follow the two-step process used under auto/facilitated enrollment (i.e. random distribution first at the sponsor level, then randomly among qualifying plans within the sponsor).

C. CMS Notification to Beneficiaries

CMS will ensure that all beneficiaries being re-assigned are notified. These notices will be on blue paper, and will instruct beneficiaries who are being reassigned because of a premium increase to contact their current plan if they wish to remain with the plan for the following year. Per section 1860 D–14 (c) of the Social Security Act, CMS will also provide reassigned beneficiaries with information on formulary differences between the individual's former plan and new plan (with respect to the individual's drug regimen), and a description of the right to coverage determination, exception, reconsideration, appeal or grievance.

D. Plan Communication to Affected Beneficiaries

Non-renewing MA plans or MA plans with a SAR are not required to send any beneficiary notices specific to the reassignment process. Please refer to the Call Letter for details on general notification requirements related to non-renewals and SARs.

"Gaining" PDPs are responsible for providing enrollment confirmation (See Exhibit 29 of Chapter 3 of the Prescription Drug Manual) and enrollment materials to beneficiaries within 10 calendar days of receiving confirmation of reassignment on a TRR.

40.2 - Processing the Enrollment Request

If an enrollment form or other enrollment mechanism is completed during a face-to-face interview, the MA organization should use the individual's Medicare card to verify the spelling of the name, and to confirm the correct recording of sex, Health Insurance Claim Number, and dates of entitlement to Medicare Part A and enrollment in Part B. If the form is mailed or faxed to the MA organization, or the enrollment request is made through another CMS approved method, the MA organization should verify this information with the individual via telephone or other means, or request that the individual include a copy of his/her Medicare card when mailing in the enrollment form. Regardless of whether or not the MA organization has reviewed the Medicare Identification card, the MA organization must still validate and verify Medicare entitlement as described in item "B" below in this section.

Appendix 2 lists all the elements that must be provided in order to consider an enrollment request "complete." If the MA organization receives an enrollment request that contains all these elements, the MA organization must consider the enrollment complete even if all other data elements on the enrollment request are not provided. If an MA organization has received CMS approval for an enrollment request that contains data elements in addition to those included in Appendix 2, then the enrollment request is considered complete even if those additional elements are not provided.

If an MA organization receives an enrollment request that does not have all necessary elements required in order to consider it complete, it must not immediately deny the enrollment. The MA organization must always check available systems (i.e. BEQ, MARx online query) for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the "sex" field on the enrollment and the MA organization has access to this information via available systems, the organization must

use that source to complete the application instead of requesting the information from the beneficiary. If the required but missing information is not available via CMS systems, the enrollment request is considered incomplete and the MA organization must follow the procedures outlined in §40.2.2 in order to complete the enrollment request.

For EGHP enrollees, the MA Organization may choose to accept enrollment requests as described in §40.1.2 or §40.1.6. All required elements as listed in Appendix 2 must be included in the record of the enrollment request provided by the group for the enrollment request to be considered complete (except signature). Follow the procedures outlined in §40.2.2 to address incomplete enrollment requests.

For enrollment requests via the Internet and telephone, as described in §40.1.2 and §40.1.4, all required elements as listed in Appendix 2 must be included except a pen-and-ink signature. The individual enrolling via this method indicates his or her intent to enroll by completing the on-line process (as described). Follow the procedures outlined in §40.2.2 to address incomplete enrollment requests.

The following should also be considered when completing an enrollment:

A. Permanent Residence Information - The MA organization must determine whether or not the enrollee resides within the MA plan's service area. If an individual puts a Post Office Box as his/her place of residence on the enrollment request, the MA organization must consider the enrollment request incomplete and must contact the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the MA organization should consult the State law in which the MA organization operates and determine whether the enrollee is considered a resident of the State.

Refer to §10 for a definition of "evidence of permanent residence," and §20.3 for more information on determining residence for homeless individuals.

B. Entitlement Information - Following the procedures outlined in the CMS Plan Communications User Guide, MA organizations must verify Medicare entitlement using the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen) for all enrollment requests, except enrollment requests from a current enrollee of an MA plan who is requesting enrollment into another MA plan offered by the same parent organization with no break in coverage (i.e. "switching plans").

Individuals are not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request. If the systems (BEQ or MARx online query) indicate that the individual is entitled to Medicare Part A and is enrolled in Part B, no further documentation of Medicare entitlement is needed from the individual.

When neither the BEQ, the MARx online query, nor MAPDIUI (Medicare Advantage Prescription Drug Interactive User Interface) beneficiary eligibility query show Medicare entitlement, the organization must consider the individual's Medicare ID card to be evidence of Medicare entitlement. When neither the BEQ/MARx/MAPDIUI query nor the Medicare ID card is available, the MA organization must consider an SSA Award Letter that shows Medicare entitlement (including start dates) as evidence of Medicare entitlement.

If the organization is not able to verify entitlement as described above, refer to §40.2.2 for additional procedures.

For auto- and facilitated enrollments, as described in §40.1.5 of this chapter, entitlement verification is deemed complete, as the individual is already an MA enrollee.

C. **Effective Date of Coverage -** The MA organization must determine the effective date of coverage as described in §30.5 for all enrollment requests. If the individual fills out an enrollment form in a face-to-face interview, then the MA organization representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the MA organization to confirm the actual effective date. The MA organization must notify the member of the effective date of coverage prior to the effective date (refer to §40.4 for more information and a description of exceptions to this rule).

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date (effective dates are described in §30.5). Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face enrollments, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §30.5.

If a beneficiary completes an enrollment request with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must notify the beneficiary in a timely manner and explain that the enrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the notification must be documented. If the beneficiary refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the enrollment request according to the procedures outlined in §60.2.1.

MA organizations must ensure enrollees have access to plan benefits as of the effective date of enrollment the MA organization has determined and may not delay provision of plan benefits in anticipation of the submission to or reply from CMS systems.

For auto- and facilitated enrollments, refer to §40.1.5 of this chapter for more information.

D. **Health Related Information -** MA organizations may not ask health screening questions during completion of the enrollment request. MA organizations are only permitted to send health assessment forms after enrollment. However, MA organizations may ask very limited health status questions related to a beneficiary's eligibility to join an MA plan, such as whether the individual has ESRD, is enrolled in Medicaid, or is currently admitted to a certified Medicare/Medicaid institution. Queries for this information are included on the model individual enrollment form in Exhibit 1, and the model EGHP form in Exhibit 2. These queries are not considered to be health screening questions. With the exception of information obtained on ESRD status, the responses to these questions must not have an effect on eligibility to enroll in an MA plan.

Exception for certain MA-SNPs - An SNP that is being offered to individuals with certain medical conditions (i.e. an SNP for chronic and disabling conditions), as

permitted by CMS, will need to establish that the individual has such a condition to determine eligibility for enrollment in that specific SNP. Refer to §20.11 for more information.

E. Statements of Understanding - As outlined in §20.5, a beneficiary must understand and agree to abide by the rules of the MA plan in order to be eligible to enroll. If the MA organization lists such statements in an itemized format, it is at the MA organization's discretion to decide whether it will:

- Consider the beneficiary signature on the form (or completion of the enrollment request process) to signify that the individual has read and understands the statements (as shown on Exhibits 1, 1b, 2 and 3); or

- Have fields next to the statements and require the applicant's initials next to each statement.

The MA organization must apply the policy consistently. If the MA organization requires the initials and the applicant fails to initial his/her understanding of each item listed on the enrollment form, the MA organization may contact the applicant to clarify the MA organization rules in order to complete the enrollment form. The MA organization must document the contact and annotate the outcome of the contact. If the MA organization is unable to contact the applicant to ensure their understanding, the enrollment form would be considered incomplete.

F. Applicant Signature and Date - The individual must sign the enrollment form or complete the enrollment request mechanism. If the individual is unable to do so, a legal representative must sign the enrollment form (refer to §40.2.1 for more detail) or complete the enrollment request mechanism. If a legal representative enrolls an individual, the legal representative must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an enrollment request on behalf of the applicant is available and can be presented upon request by the MA organization or CMS.

The individual and/or legal representative must indicate his/her relationship to the individual and date he/she signed the enrollment form or completed the enrollment request; however, if he/she inadvertently fails to include the date on the enrollment request, then the date the MA organization receives the enrollment request may serve as the signature date of the form.

If a paper enrollment form is submitted and the signature is not included, the MA organization may verify with the individual with a phone call and document the contact, rather than return the paper enrollment form as incomplete. The documentation of this contact will complete the enrollment request (assuming all other required elements are complete).

Certain enrollment request mechanisms do not include a pen-and-ink, or "wet," signature. Follow the specific procedures provided for the other enrollment request mechanism in this chapter; for example, see §40.1.3 for information about enrollment via the internet.

For auto and facilitated enrollment as described in §40.1.5, an enrollee signature is not required.

G. Other Signatures - If the MA organization representative helps the individual fill out the enrollment form, then the MA organization representative must clearly indicate his/her name on the enrollment form. However, the MA organization representative does not have to include his/her name on the form when:

- He/she pre-fills the individual's name and mailing address when the individual has requested that an enrollment form be mailed to him/her,
- He/she fills in the "office use only" block, and/or
- He/she corrects information on the enrollment form after verifying information (see "final verification of information" below).

The MA organization representative does have to include his/her name on the form if he/she pre-fills any other information, including the individual's phone number.

H. Old Enrollment Requests - If the MA organization receives an enrollment request that was executed more than 30 calendar days prior to the MA organization's receipt of the request, the MA organization is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

I. Determining the Application Date - The MA organization must date all enrollment requests as soon as they are initially received. Except for enrollment requests submitted via the CMS Online Enrollment Center, requests made by the group enrollment mechanism and auto or facilitated enrollments, the date the enrollment request is initially received is equivalent to the "application date" (refer to §10 for definitions of "receipt of enrollment request," "completed enrollment request" and "application date"). If the enrollment request is not complete at the time it is received, then the additional documentation required for the enrollment request to be complete must be dated as soon as it is received. Appendix 3 describes the appropriate application date to include in the enrollment transaction submitted to CMS under various conditions.

J. Final Verification of Information - Some MA organizations verify information before enrollment information has been transmitted to CMS. In these cases the MA organization may find that it must make corrections to an individual's paper enrollment form. The MA organization should make those corrections, and the individual making those corrections must place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the MA organization (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These types of corrections will not result in the MA organization having to co-sign the enrollment form.

K. Premiums Owed to the MAO - For individuals enrolling in an MA-only (non MA-PD) plan, an MA organization may choose to wait for an enrolling individual's payment of the MA-only plan premium before considering the enrollment request complete. An MA organization cannot consider an enrollment request incomplete if the individual enrolling has indicated that he or she wants the plan premium withheld from an SSA benefit check.

For enrollment into either an MA-only or MA-PD plan, an MA organization may consider an enrollment request incomplete if there are premium amounts due to the organization from a prior enrollment, whether or not premium withhold from an SSA benefit check is selected.

The option chosen by the MA plan to consider the application complete or incomplete must be applied consistently to all potential enrollees of the plan.

Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low Income Subsidy

For enrollment requests submitted by dually eligible individuals and individuals who qualify for the low income subsidy (LIS), an MA organization may consider an enrollment request complete if there are premium amounts due to the organization from a prior enrollment, even if the MA organization has a policy to consider such enrollment requests incomplete.

The MA organization has the discretion to implement this exception to dually eligible individuals and individuals who qualify for LIS within each of its MA plans. If the MA organization offers this exception in one of its plans, it must apply the policy to all such individuals who request enrollment in that MA plan.

L. Completed Enrollment Requests - Once the enrollment request is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4 within the prescribed time frames. There are instances when a complete enrollment can turn out to be legally invalid. These instances are outlined in §40.6.

M. Plan Premium Payment and Premium Withhold Options - At a minimum, all organizations must include on all enrollment request mechanisms the option for individuals to: 1) pay plan premiums by being billed directly by the plan or 2) have the premiums withheld from their SSA benefit check. The plan may also choose to offer other payment methods, such as automatic deduction from the individual's bank or other financial institution or from the individual's credit card. The enrollment mechanism must also advise that if the individual does not select a premium payment option, the default action will be direct bill.

MA-only plans that do not have a premium may omit the "Paying your Plan Premium" section from their enrollment request mechanism. MA-PD plans that do not have a plan premium must include, at minimum, the direct bill and SSA withhold options for those individuals subject to the LEP to select how they will pay this penalty (premium); however, such plans may include introductory language to indicate that the premium payment section applies only to individuals subject to the LEP.

Railroad Retirement Board (RRB) enrollees may also submit requests to have their premiums withheld from their RRB retirement payments. Organizations must offer this option on all enrollment mechanisms as well.

MA-PD plans must also include on all enrollment request mechanisms a statement in the premium payment section advising those individuals who qualify for extra help that, if

the extra help does not cover the entire plan premium, the individual is responsible for the amount that Medicare does not cover.

Model language has been provided on Exhibits 1, 1c, 3 and 3a to reflect the required options. In addition, suggested optional language for MA-PD plans without premiums has also been provided.

At this time, OPM is unable to process withhold requests.

N. **Additional Information for MA-PD Enrollment Requests –** Individuals enrolling in a Part D plan must disclose any other existing coverage for prescription drugs.

40.2.1 - Who May Complete an Enrollment or Disenrollment Request

A Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in or disenrollment from an MA plan. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the State in which the beneficiary resides may allow. CMS will recognize State laws that authorize persons to make such requests for Medicare beneficiaries. For example, persons authorized under State law may be court-appointed legal guardians, persons having durable power of attorney for health care decisions or individuals authorized to make health care decisions under State surrogate consent laws, provided they have authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request or complete an enrollment request mechanism due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the enrollment request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, MA organizations should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

Where MA organizations are aware that an individual has a representative payee designated by SSA to handle the individual's finances, MA organizations should contact the representative payee to determine his/her legal relationship to the individual, and to ascertain whether he/she is the appropriate person, under State law, to execute the enrollment or disenrollment request. Representative payee status alone is not sufficient to enroll a Medicare beneficiary.

When someone other than the Medicare beneficiary completes an enrollment or disenrollment request, he or she must:

1) Attest to having the authority under State law to do so;
2) Confirm that proof of authorization, if any, required by State law that empowers the individual to make an enrollment or disenrollment request on behalf of the individual is available and can be provided upon request by CMS. MA organizations cannot require such documentation as a condition of enrollment or disenrollment; and
3) Provide contact information.

The MA organization must retain the record of this attestation as part of the record of the enrollment or disenrollment request. CMS will provide a sample attestation as part of the model MA enrollment form (Exhibit 1).

If anyone has reason to believe that an individual making an election on behalf of a beneficiary may not be authorized under State law to do so, the organization should contact its CMS account manager with all applicable documentation regarding State Law and the case in question. The account manager may request supporting documentation from the individual making the election.

When an authorized representative completes an enrollment request on behalf of a beneficiary, the MA organization should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e. sending mail to the beneficiary directly or to the representative, or both) and make reasonable accommodations to satisfy these wishes.

40.2.2 - When the Enrollment Request Is Incomplete

When the enrollment request is incomplete, the MA organization must document all efforts to obtain additional documentation to complete the enrollment request and have an audit trail to document why the enrollment request needed additional documentation before it could be considered complete. The organization must make this determination and, within 10 calendar days of receipt of the enrollment request, must notify the individual that additional information is needed, unless the required but missing information can be obtained via CMS systems. This notification is not required for SNP enrollment requests for which the only missing information is confirmation of the applicant's special needs status.

Note: An enrollment request is considered complete even if the only information missing is the eligibility for the election period. In such circumstances, the plan must contact the individual to assure they have a valid election period before processing the enrollment. (See Section 30 for more information regarding eligibility for election periods and Section 40 for enrollment processing requirements.)

For incomplete ICEP enrollment requests received prior to the month of entitlement to Part A and enrollment in Part B, additional documentation to make the request complete must be received during the first three months of the ICEP, or within 21 calendar days of the request for additional information (whichever is later). For incomplete ICEP enrollment requests received during the month of entitlement to Part A and enrollment in Part B or later, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

For incomplete AEP enrollment requests, additional documentation to make the request complete must be received by December 7, or within 21 calendar days of the request for additional information (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

Examples

- Ms. Stears' 65th birthday is April 20, 2011. She is eligible for Medicare Part A and Part B beginning April 1, 2011 and has decided to enroll in Part B beginning on April 1. Her ICEP begins on January 1, 2011 and ends on July 31, 2011. She submits an incomplete ICEP enrollment request on January 15, 2011, and the MAO requests the required but

missing information on January 20, 2011. The enrollment request must be denied if the required information is not received by March 31, 2011.

- Ms. Mohan's 65th birthday is June 10, 2011. She is eligible for Medicare Part A and Part B beginning June 1, 2011 and has decided to enroll in Part B beginning on June 1. Her ICEP begins on March 1, 2011 and ends on September 30, 2011. She submits an incomplete ICEP enrollment request on July 5, 2011, and the MAO requests the required but missing information on July 7, 2011. The enrollment request must be denied if the required information is not received by July 31, 2011.

When the MA organization receives an incomplete enrollment request near the end of either a month or an enrollment period, the use of the full 21 calendar day period to complete the request may extend beyond CMS systems plan submission "cut-off" date (these dates are provided in the CMS Plan Communications User Guide). MA organizations may utilize a code 61 enrollment transaction to directly submit the request to CMS as provided in the CMS Plan Communications User Guide.

If additional documentation needed to make the enrollment request "complete" is not received within allowable time frames, the organization must deny the enrollment using the procedures outlined in §40.2.3.

Requesting Information from the Beneficiary - To obtain information to complete the enrollment request, the MA organization must contact the individual to request the information within ten calendar days of receipt of the enrollment request. The organization may contact the beneficiary either in writing (see Exhibit 5 for a model letter) or orally. If the contact is made orally, the MA organization must document the contact and retain the documentation in its records. The MA organization must explain to the individual that s/he has 21 calendar days in which to submit the additional information or the enrollment will be denied. Since an incomplete enrollment request is an invalid enrollment (as explained in §40.6), if the additional documentation is not received within allowable time frames, the MA organization must send a denial of enrollment letter (see Exhibit 7).

If all documentation is received within allowable time frames and the enrollment request is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4.

40.2.3 - MA Organization Denial of Enrollment

MA organization denials occur before the organization has transmitted the enrollment to CMS. For enrollment requests that do not require additional information from the applicant, an MA organization must deny an enrollment within 10 calendar days of receiving the enrollment request based on its own determination of the ineligibility of the individual to elect the MA plan. For an incomplete enrollment request that requires information from the applicant and for which the applicant fails to provide the information within the required time frame, an MA organization must deny the enrollment within 10 calendar days of the expiration of the time frames described in §40.2.2.

Notice Requirement - The organization must send notice of the denial to the individual that includes an explanation of the reason for denial (refer to Exhibit 7 for a model notice). This notice must be sent within ten calendar days of either 1) receipt of the enrollment request or 2)

expiration of the time frame for receipt of requested additional information, as described in the following examples:

- An MA organization receives an enrollment request from an individual on November 7 and determines on that same day that the individual is ineligible due to place of residence. The organization should send notice of denial within ten calendar days from November 7.

- An MA organization receives an enrollment request from an individual on January 7 and is unable to determine, through direct contact with the beneficiary or the beneficiary's authorized representative, that the beneficiary has a valid enrollment period available. The organization should send notice of denial within ten calendar days from January 7.

- An MA organization receives an enrollment form on November 7 from an individual, identifies the enrollment form as incomplete, and notifies the individual of the need for additional information, on November10. The beneficiary does not submit the information by December (as required under §40.2.2), which means the organization must deny the enrollment. The organization should send notice of denial within ten calendar days from December 1.

40.2.4 - ESRD and Enrollment

If an MA organization is aware that an individual requesting enrollment into a plan no longer requires regular dialysis or has received a kidney transplant (e.g., the individual informs the MA organization that this has occurred), then the MA organization should request that the individual submit medical documentation (i.e., a letter from the physician that documents that the individual has received a kidney transplant or no longer requires a regular course of dialysis to maintain life), using the procedures outlined in §40.2.2. Upon receipt of this documentation, the MA organization must enroll the beneficiary using the override procedures described in the CMS Plan Communication Users Guide.

If an individual indicates on the enrollment request that he/she does not have ESRD, but the MA organization receives a CMS systems reply containing a "code 45" or "code 15" rejection (an explanation of transaction reply codes is contained in the Plan Communication Users Guide), the MA organization must investigate further to determine whether the individual is eligible to enroll by means of any one of the exceptions in §20.2.2 of this chapter. To determine eligibility, the MA organization may contact the individual to request medical documentation using the procedures outlined in §40.2.2. Contact can be made orally, in which case the MA organization must document the contact and retain the documentation in its records.

If the MA organization learns that the individual is eligible to enroll for any of the exceptions provided in §20.2.2 of this chapter, the individual must be permitted to enroll in the MA plan if other applicable eligibility requirements are met. The MA organization must submit the enrollment transaction with the ESRD Override field completed as instructed in the Plan Communication Users Guide if the effective date of enrollment is within the current operating month for direct submission of the transaction. If the effective date of enrollment is "retroactive" (for CMS systems submission purposes) the request must be submitted to the CMS Retroactive Processing Contractor with the following documentation:

1. Copy or record of the completed enrollment request, and

2. A description of the individual's circumstances related to at least one of the exceptions in §20.2.2 of this chapter by which the individual has been determined eligible to enroll by the MA organization

ESRD and MA Plan Terminations

Certain individuals with ESRD who have been impacted by MA terminations will be permitted to make one enrollment request into a new MA plan (refer to §20.2 for a discussion of who is eligible to make an enrollment request). Beneficiaries will be instructed to save their notification letters to present, if requested, to MA organizations as proof of their eligibility to join a plan. The CMS' system will edit incoming enrollment transactions for ESRD beneficiaries to determine:

1. If they were a member of a terminating or terminated MA plan; and
2. If they have already used their one enrollment request.

Enrollments for these individuals should be submitted as normal transactions with all other transactions. The enrollment will be allowed if the individual is eligible, and will be rejected if not.

40.2.5 - MA-PD Enrollment When an Individual has Other Qualified Prescription Drug Coverage Through an Employer or Union Retiree Drug Subsidy (RDS) Plan Sponsor

CMS systems will compare MA-PD enrollment transactions to information CMS has regarding the existence of employer or union sponsored qualified prescription drug coverage for which the beneficiary is also being claimed for the Retiree Drug Subsidy (RDS). If there is a match indicating that the individual may have such other coverage, the enrollment will be conditionally rejected by CMS systems as incomplete.

Within 10 calendar days of receipt of the Code 127 conditional rejection, the MA organization must contact the individual to confirm the individual's intent to enroll, and that the individual has discussed and understands the implications of enrollment in a Part D plan on his or her employer or union coverage. Individuals will have 30 calendar days from the date they are contacted to respond. The organization must ensure that plan benefits are available to the individual as of the effective date of the initial enrollment request and must not delay the provision of plan benefits in anticipation of the applicant's confirmation of intent to enroll. The organization may contact the individual in writing (See Exhibit 6b) or by phone and must document this contact and retain it with the record of the individual's enrollment request. If the individual indicates that s/he is fully aware of any consequence to his/her employer or union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the MA organization must update the transaction with the appropriate "flag" (detailed instructions for this activity are included with CMS systems guidance) and re-submit it for enrollment. The effective date of enrollment will be based upon the individual's initial enrollment request. This effective date may be retroactive in the event that the confirmation step occurs after the effective date. MA organizations may use the Code 61 enrollment transaction code to submit the enrollment transaction directly to CMS, as described in the Plan Communication Users Guide (PCUG).

MA organizations are strongly encouraged to closely monitor their outreach efforts and to follow up with applicants prior to expiration of the 30 day timeframe. If the individual does not respond

in 30 days, or responds and declines the enrollment, the enrollment must be denied. A denial notice must be provided (see Exhibit 7).

When an employer or union sponsored MA-PD plan is replacing an existing RDS plan offered by that employer or union group, the MA organization may receive the Code 127 conditional rejection. In these cases it is not necessary to contact each individual, as described above. The MA organization must resubmit the transactions updated with the appropriate flag.

MA organizations should work in close collaboration with employer/union sponsors who are replacing RDS coverage with Part D coverage to ensure that all individuals are aware of the change and have the information they need.

40.3 - Transmission of Enrollments to CMS

For all enrollment requests effective January 1, 2008, or later that the organization is not denying per the requirements in §40.2.3, the MA organization must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the MA organization within 7 calendar days of receipt of the **completed** enrollment request. CMS system "down" days are included in the calculation of the 7 calendar days (refer to Appendix C of the Plan Communications User Guide). For the purpose of assessing compliance with this requirement, CMS will count the enrollment request receipt date as "day zero" and the following day as "day one." In the case of enrollment requests that are accepted after the MA organization is enrolled to capacity, but as a vacancy occurs, the MA organization must submit the information within 7 calendar days after a vacancy has become available.

All enrollment elections must be processed in chronological order by date of receipt of completed enrollment elections (refer to §40.5 for procedures when the MA plan is closed for enrollment).

MA organizations are encouraged to submit transactions by the earliest possible MA organization processing cutoff date (refer to Chapter 19). However, if the organization misses the cutoff date, it must still submit the transactions within the required 7 calendar day time frame.

> **NOTE:** The requirement to submit the transaction within 7 calendar days does not affect the effective date of the individual's coverage under the plan, i.e., the effective date must be established according to the procedures outlined in §§30.5 and 30.7.

More detail on how MA organizations must submit transmissions to CMS are contained in the Medicare Advantage and Prescription Drug Plans Plan Communications User Guide.

40.4 - Information Provided to Member

Much of the enrollment information that an MA organization must provide to the member must be sent prior to the effective date of coverage. However, some information will be sent after the effective date of coverage. A member's coverage begins on the effective date regardless of when the member receives all the information the plan sends.

As discussed previously (§40), the organization must provide required notices in response to information received from CMS on the TRR that provides the earliest notification. Organizations

may choose to send notifications based on the availability of each Batch Completion Summary Status (BCSS) file if they desire. However, in no case may use of the BCSS for this purpose extend any timeframe established in this guidance. Organizations choosing to utilize the BCSS for certain required beneficiary notifications must do so consistently.

The organization may provide the required notices described in §§40.4.1 and 40.4.2 or may utilize a single ("combination") notice (see Exhibits 4b and 4e). The combination notice takes the place of separate acknowledgement and confirmation notices and, as such, requires expedited issuance. To use the combination notice, the organization must be able to provide this notice within 7 calendar days of the availability of the TRR. Additionally, when following this option to use the combination notice, if the organization is unable to ensure that the beneficiary will receive this combination notice prior to the enrollment effective date (or within timeframes for incomplete enrollment requests or enrollments received at the end of the month), the organization still must ensure that the beneficiary has the information required in §40.4.1 within the timeframes described therein.

If an individual's enrollment includes a request for SSA or RRB premium withhold and was processed after the monthly cut-off for payment, the organization must submit the request for premium withhold separate from the enrollment request. Plans should resubmit the request for premium withhold timely to assure the individual can have premium withholding at the next possible effective date. Additionally, the organization must inform the individual that:

- If his/her request for premium withholding is approved, it will start in 1-2 months;
- The effective date for premium withholding will not be retroactive;
- S/he will be responsible for paying the organization directly for all premiums due from the enrollment effective date until the month in which premium withholding begins; and
- For plans implementing §50.3.1, failure to pay premiums for months in which premium withholding is not in effect will result in disenrollment from the plan.

40.4.1 - Prior to the Effective Date of Coverage

Prior to the effective date of coverage the MA organization must provide the member with all the necessary information about being a Medicare member of the MA organization, the MA organization rules, and the member's rights and responsibilities (an exception to this requirement is described in §40.4.2). The MA organization must also provide the following to the individual:

- For paper enrollment requests, a copy of the paper enrollment form, if the individual does not already have a copy of the form.
- For enrollment requests submitted via the internet, evidence that the online enrollment request was received (e.g., a confirmation number).
- For enrollments submitted via telephonic enrollment, evidence that the telephonic enrollment request was received (e.g., a confirmation number).
- A notice acknowledging receipt of the completed enrollment request (refer to Exhibits 4, 4a, and 4c for model letters) and showing the effective date of coverage. This notice must

be provided no later than 10 calendar days after receipt of the completed enrollment request (organizations choosing to use the combination notice, refer to 40.4 above).

- Proof of health insurance coverage so that he/she may begin using plan services as of the effective date. This proof must include the 4Rx data necessary to access benefits.

  NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in the Medicare Marketing Guidelines. The proof of coverage may be in the form of member ID cards, the enrollment form, and/or a notice to the member (refer to Exhibits 4, 4a, 4b and 4c, which are model letters with optional language that would allow the member to use the letter as evidence of health insurance coverage until he/she receives a member card). As of the effective date of enrollment, plan systems should indicate active membership.

Regardless of whether an enrollment request is made in a face-to-face interview, by fax, by mail, or by other mechanisms defined by CMS, the MA organization must explain:

- The charges for which the prospective member will be liable, e.g., any premiums (this includes any Part D late enrollment penalty), coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance, if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).

- The prospective member's authorization for the disclosure and exchange of necessary information between the MA organization and CMS.

- The lock-in requirement. The MA organization must also obtain an acknowledgment by the individual that he/she understands that care will be received through designated providers except for emergency services and urgently needed care.

- The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B at the time coverage begins and he/she has used MA plan services after the effective date.

- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the MA organization has not yet provided the ID card).

40.4.2 - After the Effective Date of Coverage

The CMS recognizes that in some instances the MA organization will be unable to provide the materials and required notifications to new enrollees prior to the effective date, as required in §40.4.1. These cases will generally occur when an enrollment request is received late in a month with an effective date of the first of the next month. In these cases, the MA organization still must provide the member all materials described in §40.4.1 no later than 10 calendar days after receipt of the completed enrollment request. Additionally, the MA organization is also strongly encouraged to call these new members as soon as possible (such as within 1-3 calendar days) to provide the effective date, the information necessary to access benefits and to explain the MA organization rules. The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.

Acceptance/Rejection of Enrollment

Once the MA organization receives a TRR from CMS indicating whether the individual's enrollment has been accepted or rejected, the MA organization must notify the individual in writing of CMS' acceptance or rejection of the enrollment within ten calendar days of the TRR that contains the earliest notification of the acceptance or rejection (see Exhibits 4d, 6, 6a, 6c, 6d and 8 for model letters). The enrollment confirmation notice must explain the charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance. For those eligible for the low-income subsidy, the enrollment confirmation notice must specify the limits applicable to the level of subsidy to which the person is entitled.

There are exceptions to this notice requirement for certain types of transaction rejections. These exceptions exist so as not to penalize the individual for a systems issue or delay, such as a plan transmission or keying error. In addition, this notice requirement does not apply to the scenario in which a transaction rejection due to ESRD, no Medicare Part A and/or no Medicare Part B is received and the MA organization has evidence to the contrary. In this case, the MA organization should not send a rejection notice and must request a retroactive enrollment from CMS (or its designee) within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. If CMS (or its designee) is unable to process the retroactive enrollment due to its determination that the individual is not eligible, the MA organization must notify the individual of the rejection in writing within ten calendar days after CMS' (or its designee's) determination. Retroactive enrollments are covered in more detail in §60.4.

If an MA organization rejects an enrollment and later receives additional information from the individual substantiating his/her eligibility, the MA organization must obtain a new enrollment request from the individual in order to enroll the individual, and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §60.4 for more information regarding retroactive enrollments.

40.5 - Enrollment Processing During Closed Periods

As described in §40.3, an MA organization must process elections in order by date of receipt of completed enrollment election when it is open for enrollment. However, an MA organization may close an MA plan to OEPI enrollments or when it reaches a CMS-approved capacity limit. This section addresses procedures for handling enrollments that arrive at the MA organization when an MA plan is closed for enrollment, and for processing those enrollments when the MA plan re-opens or a vacancy occurs.

If an MA organization believes its MA plan does not have the capacity to accept additional members, or as the MA plan enrollment grows and the MA organization estimates it may reach capacity during its next open enrollment period, the MA organization may request a CMS-approved limit on enrollment.

A capacity limit allows an MA organization to close or limit enrollment during the AEP, ICEP, and SEP. Only with a reserved vacancy may an MA organization set aside vacancies for enrollment of conversions.

40.5.1 - Procedures After Reaching Capacity

If the number of individuals who elect to enroll in an MA plan exceeds a CMS-approved capacity limit, then the MA organization may limit enrollment of these individuals, but only if it provides priority in acceptance.

If an MA organization receives completed enrollment requests between the time it reaches its limit and the time CMS approves the limit, it may follow one of two options **after it receives approval from CMS to limit enrollment:** (1) Deny the enrollment due to the onset of the capacity limit, or (2) Place the enrollment on a waiting list to be processed as vacancies occur in the priority of acceptance. This priority requires that the MA organization process enrollments from individuals who elected the MA plan prior to CMS' determination that the capacity has been exceeded, in order based on date of receipt of the completed enrollment request, and in a manner that does not discriminate on the basis of any factor related to health as described in 42 CFR §422.110.

The MA organization must take the same action for all enrollment requests received. See below for procedures for following options 1 or 2.

After the enrollments discussed in the above paragraph are acted upon, the MA organization has similar options for handling any additional enrollment requests received while the plan is closed for enrollment. The MA organization may follow one of two options: (1) Deny the enrollment due to the capacity limit, or (2) Place the enrollment on a waiting list to be processed when the plan re-opens for enrollment. However, to ensure no discrimination is applied to applications processed, all MA organizations that use option 1 (i.e., deny enrollment) for enrollments discussed in the above paragraph, must continue to deny all enrollments received while the plan is closed for enrollment, and may not use option 2. The MA organization must take the same action for all enrollment forms received. In the case of enrollments received after the plan closes for enrollment, the date the MA plan re-opens becomes the "receipt date" of enrollment forms received when the plan was closed.

> **EXAMPLE:** If the plan was closed in April and re-opens on May 1, then the receipt date of enrollment requests received in April is May 1. See below for procedures for following options 1 or 2.

If the MA Organization Uses Option 1 - It must notify the individual in writing that it is denying the enrollment, and should do so within ten calendar days after it receives the enrollment request or after the MA organization receives approval from CMS to limit enrollment (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

If the MA Organization Uses Option 2 - It must notify the individual in writing that he/she has been placed on a waiting list, and should do so within ten calendar days after the MA organization receives the enrollment request or after the MA organization receives approval from CMS to limit enrollment. The notice must also provide an estimated length of time that the individual will be on a waiting list and instruct the individual that he may cancel his enrollment before a vacancy occurs.

As enrollment spaces become available, if the plan was closed for more than 30 calendar days since the receipt of the enrollment form, the MA organization must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The MA organization may make this contact even if the plan was closed for less than 30 days.) Within ten calendar days after contacting the individual, the MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc.

There may be situations in which the MA organization has closed enrollment in a service area, yet receives an approval for a capacity limit for a portion of that same service area. Given that MA plans are either open or closed for an ENTIRE service area, any vacancies which may open up may only be filled by individuals in their ICEP or SEP by applying the rules of accepting enrollments when MA plans are closed (see §40.5.2 below). Further, it must take those individuals based upon enrollments received in chronological order.

40.5.2 - Procedures After Closing During the OEPI

As stated in §30, an MA organization must accept all enrollment requests for its MA plans made during the AEP, ICEP, or SEP. However, an MA organization may not process **OEPI** enrollments for a plan when the plan is closed to OEPI enrollments.

If an MA plan is closed to OEPI enrollments and receives new OEPI enrollment forms or documentation to complete OEP enrollment forms already received by the MA organization, then the MA organization may do one of the following. The MA organization must take the same action for all enrollment forms received while the plan is closed:

1. Deny the enrollment;
2. Continue to accept the completed enrollment forms to be placed on a waiting list.

If the MA Organization uses option #1 above - It must notify the individual in writing that it is denying the enrollment, and should do so within ten calendar days after it receives the enrollment request (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

If the MA Organization uses option #2 above - it must notify the individual in writing that he/she has been placed on a waiting list. The notice must inform the individual that the enrollment request will not be processed until the plan re-opens for enrollment, must include the date the plan will re-open, and must inform the individual that he/she may cancel the request for enrollment before the plan re-opens. All individuals who wish to wait for an opening must be placed on the waiting list.

After the MA plan re-opens, if the plan was closed for more than 30 calendar days since the MA organization received the enrollment request, it must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The MA

organization may make this contact even if the plan was closed for less than 30 days.) The MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan, and should do so within ten calendar days after contacting the individual.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc. The date the MA plan re-opened becomes the "receipt date" of enrollment forms received when the plan was closed.

> **EXAMPLE:** If the plan was closed in February and re-opens on March 1, then the receipt date of enrollment requests received in February is March 1.

40.6 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive cancellation of enrollment action may be necessary (refer to §60.5 for more information on retroactive disenrollments). In addition, a reinstatement to the plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from his/her original plan of choice.

An enrollment that is not complete, as defined in §10, is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if an MA organization determines at a later date that the individual provided an incorrect permanent address at the time of enrollment and the actual address is outside the MA plan's service area. A second example could be an instance where an individual not authorized by State law to make an enrollment request on another's behalf attempts to complete an enrollment request.

There are also instances in which an enrollment that appears to be complete can turn out to be legally invalid. In particular, CMS does not regard an enrollment as actually complete if the member or his/her legal representative did not intend to enroll in the MA organization. If there is evidence that the individual did not intend to enroll in the MA organization, the MA organization should submit a retroactive disenrollment request to CMS. Evidence of lack of intent to enroll by the individual may include:

- An enrollment request signed by the individual when a legal representative should have signed for the individual;
- Request by the individual for cancellation of enrollment before the effective date (refer to §60.2 for procedures for processing cancellations);
- Enrolling in a supplemental insurance program immediately after enrolling in the MA organization; or
- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

Payment of the premium does not necessarily indicate an informed decision to enroll. For example, the individual may believe that he/she was purchasing a supplemental health insurance policy, as opposed to enrolling in an MA organization. In addition, use of an MA plan doctor does not necessarily indicate an understanding of the lock-in requirement if the doctor also treats non-plan members.

40.7 - Enrollment Procedures for Medicare MSA Plans

MA organizations offering a Medicare MSA plan must follow the procedures outlined in §§40.2, 40.3, 40.4, 40.5.1, and 40.6. MSA plans must have a paper enrollment form available for eligible individuals to request enrollment. Exhibit 1b is a model MSA plan enrollment form. Organizations may use this model form as it appears or may customize their enrollment forms based on this model, if they follow usual Medicare marketing material approval practices and ensure all the required MSA specific elements are included. Applications for Medicare MSAs must include a question regarding election of the Medicare hospice benefit.

All information necessary to successfully enroll the individual in the MSA plan must be provided to consider the enrollment request complete, including the answers to questions 1 – 4 on the model MSA enrollment form. Additionally, the organization must obtain the necessary banking and account information before the enrollment can be considered complete. The MA organization must ensure its materials describing the MSA plan explain the details of having the MSA account and what options the individual will have regarding the account.

Beneficiaries may enroll into a Medicare MSA plan only through the MA organization offering that plan. Beneficiaries may enroll directly with the plan by completing an approved paper enrollment form. Additionally, MSA plans may offer an online enrollment mechanism as defined in §40.1.2 through the organization's website. MSA plans are not available through the Online Enrollment Center on the Medicare.gov website.

40.7.1 - Establishing the MSA Banking Account during the Enrollment Process

Medicare beneficiaries interested in enrolling in a MSA plan will need to establish an MSA bank account to accept MSA deposits in accordance with the MSA plan's procedures. The MA Organization must have documentation that a beneficiary will open the MSA account before submitting an enrollment transaction to MARx for that beneficiary. CMS will make the annual deposit payment to the plan on the same schedule as the monthly capitation payment. Per Section 1853(e)(2) of the Act, payment of an MSA deposit cannot be made until the beneficiary account has been established.

Acceptable documentation that an MSA account has been established includes a written/electronic notice from the bank that the beneficiary has opened an MSA account, or a written/electronic communication from the beneficiary that the MSA account has been opened, with the bank routing number and account number reported on the communication. The MSA organization must retain this documentation. Described below are several procedures that the MSA Organization could implement to facilitate the establishment of these MSA accounts:

1. The organization provides the beneficiary with specific banking enrollment materials to begin the process necessary for establishment of the MSA banking account. The specified bank supplies the beneficiary with the required signature card and items needed for establishing the account. The beneficiary completes and returns the required documents to the specified bank. The bank provides the information to the MSA plan to complete the enrollment transaction.

2. For an employer/union sponsored MSA plan, the plan's designated bank deals directly with the employer or union allowing the employer or union to facilitate the establishment of an account on behalf of the Medicare beneficiaries enrolling in the MSA plan.

Finally, these procedures must accommodate the following guidance:

- MSA organizations must educate beneficiaries that the enrollment is not complete until the MSA account is set up.
- The organization must have documentation that the account has been established prior to submitting the enrollment transaction to CMS.
- MSA organizations must educate beneficiaries that once the enrollee's initial deposit has been received in the MSA account the enrollee may then transfer the funds to his or her own banking institution.

MARx will not reject an MSA enrollment transaction if CMS records show an open period of Medicaid or Hospice coverage; however, MARx will provide information about these statuses. MSA plans should contact the beneficiary to confirm or deny this information.

50 - Disenrollment Procedures

42 CFR 422.74

Except as provided for in this section, an MA organization may not, either orally or in writing, or by any action or inaction, request or encourage any member to disenroll. While an MA organization may contact members to determine the reason for disenrollment, the MA organization must not discourage members from disenrolling after they indicate their desire to do so. The MA organization must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

All notice requirements are summarized in Appendix 1.

NOTE: It is not necessary for an MA plan to send a notice of disenrollment to beneficiaries whose plan benefit package (PBP) number is changed as part of a CMS-approved plan renewal. The annual notice of change that the MA organization sends to the beneficiaries as part of the end-of-year activities serves this function. Instructions and information on the annual notice of change can be found in§60.7 of Chapter 3 of the Medicare Managed Care Manual.

50.1 - Voluntary Disenrollment by Member

A member may request disenrollment from an MA plan only during one of the election periods outlined in §§30 and 30.7. The member may disenroll by:

1. Enrolling in another plan (during a valid enrollment period);
2. Giving or faxing a signed written notice to the MA organization, or through his/her employer or union, where applicable;
3. Submitting a request via the Internet to the MA organization (if the MA organization offers such an option); or
4. Calling 1-800-MEDICARE.

If a member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above. The MA organization may send a disenrollment form to the member upon request (see Exhibits 9, 9a, and 10).

The disenrollment request must be dated when it is initially received by the MA organization.

Per §40.2.1, when someone other than the Medicare beneficiary completes a disenrollment request, he or she must:

1. Attest that he or she has the authority under State law to make the disenrollment request on behalf of the individual;
2. Attest that proof of this authorization (if any), as required by State law that empowers the individual to effect a disenrollment request on behalf of the applicant is available upon request by the MA organization or CMS; and
3. Provide contact information.

50.1.1 – Requests Submitted via Internet

The MA organization has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The MA organization must, at a minimum, comply with the CMS security policies - found at http://www.cms.hhs.gov/informationsecurity/. However, the MA organization may also include additional security provisions. The CMS policies indicate that with regard to receiving such disenrollments via the Internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

In addition, CMS policies require MA organizations to provide the CMS Office of Information Services with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the MA organization is complying with the required encryption, authentication, and identification requirements. The CMS reserves the right to audit the MA organization to ascertain whether it is in compliance with the security policy. The effective date of the request is determined by the election period in which the valid request was received by the MA organization. The election period is determined by the date the request is received at the site designated by the MA organization, as described in member materials.

The option of online disenrollment is limited to requests submitted via the MA organization's website. Online disenrollment via other means, such as a broker website, as well as disenrollment requests submitted via email, are not permitted.

50.1.2 - Request Signature and Date

When providing a written request, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §40.2.1 for more detail on who may complete enrollment and disenrollment requests). If a legal representative signs the request for the individual, then he or she must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect a disenrollment request on behalf of the applicant is available and can be presented upon request to the MA organization or CMS.

The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the date of receipt that the MA organization places on the request form will serve as the signature date.

If a written disenrollment request is received and the signature is not included, the MA organization may verify with the individual or legal representative with a phone call and document the contact, rather than return the written request as incomplete.

50.1.3 - Effective Date of Disenrollment

The election period during which the organization received a valid request to disenroll will determine the effective date of the disenrollment; refer to §§30.6 and 30.7 for information regarding disenrollment effective dates.

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date. Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §§30.6 and 30.7.

If a beneficiary submits a disenrollment request with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must call or write the beneficiary to explain that the disenrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the call must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary can cancel the disenrollment request according to the procedures outlined in §60.2.2.

50.1.4 - Notice Requirements

After the member submits a request, the MA organization must provide the member with a disenrollment notice within ten (10) calendar days of receipt of the request to disenroll. The disenrollment notice must include an explanation of the lock-in restrictions for the period during which the member remains enrolled in the organization, and the effective date of the disenrollment (see Exhibit 11). The MA organization may also advise the disenrolling member to hold Original Medicare claims for up to one month so that Medicare computer records can be updated to show that the person is no longer enrolled in the plan. For these types of disenrollments, i.e., disenrollments in which the member has disenrolled directly through the MA organization, MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment notice after receiving CMS confirmation of the disenrollment from the TRR.

Since Medicare beneficiaries have the option of disenrolling through sources other than the MA organization (such as 1-800-MEDICARE or by enrolling in another Medicare managed care plan or PDP), the MA organization will not always receive a request for disenrollment directly from the member and will instead learn of the disenrollment through the CMS TRR. If the MA organization learns of the voluntary disenrollment from the CMS TRR (as opposed to through written request from the member), the MA organization must send a written confirmation notice of the disenrollment to the member within ten calendar days of the availability of the TRR (see Exhibit 12). Organizations may choose, but are not required, to issue a disenrollment confirmation notice for an automatic disenrollments resulting from an individual's enrollment in a PBP within the same MA contract.

If the MA organization receives a disenrollment request that it must deny, the organization must notify the enrollee within 10 calendar days of the receipt of the request, and must include the reason for the denial (see Exhibit 12a).

An MA organization may deny a voluntary request for disenrollment only when:

1. The request was made outside of an allowable period as described in §30 of this guidance; or
2. The request was made by someone other than the enrollee and that individual is not the enrollee's legal representative (as described in §40.2.1).

3. The request was incomplete and the required information is not provided within the required time frame (as described in §50.4.2).

50.1.5 - Optional Employer/Union MA Disenrollment Request Mechanism

As described in §20.4.1 of this chapter, beginning April 1, 2003, MA organizations that offer employer or union group-sponsored MA plans may choose to accept voluntary disenrollment requests from beneficiaries enrolled in those plans directly from the employer or union (or its TPA) without obtaining a written disenrollment request from each individual. The disenrollment must be prospective from the date the request is received by the employer/union group.

- The MA organization must inform its Regional Office Account Manager of its intent to use this mechanism and identify the employer(s) or union(s) for which it will be accepting disenrollments made in this manner.
- The disenrollment information (i.e., the electronic file) submitted to the MA organization by the employer or union (or TPA) must accurately reflect the employer's or union's record of the disenrollment made by each individual according to the processes the employer or union has in place, and may be accepted without a paper MA disenrollment request form.
- This alternate disenrollment request mechanism is used in place of paper MA disenrollment request forms and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the MA organization receipt date will be the date the employer's or union's record of an individual's disenrollment choice is received by the MA organization. MA organizations must record these dates.
- Effective date calculation of voluntary disenrollments and the collection and submission of disenrollments to CMS will follow existing procedures.
- To accept electronic records of employer or union disenrollment requests, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information. (See the CMS Web site at: http://www.cms.hhs.gov/informationsecurity for additional information.)
- The employer's or union's record of the disenrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the MA organization and/or CMS as necessary, and be maintained (by the employer/union or the MA organization, as they agree) for at least 6 years following the effective date of the individual's disenrollment from an MA plan. The MA organization must maintain its record of information received from the employer or union following the guidelines for MA disenrollment request forms (see §60.9).

50.1.6 - Group Disenrollment for Employer/Union Sponsored Plans

CMS is providing a process for group disenrollment from an employer or union sponsored MA plan. CMS will allow an employer or union to disenroll its retirees from an employer or union sponsored MA plan using a group disenrollment process.

The group disenrollment process must include notification to each beneficiary as follows:

- All beneficiaries must be notified that the employer or union intends to disenroll them from the MA plan that the employer or union is offering; and
- This notice must be provided by the MA organization, employer, or union not less than 21 calendar days prior to the effective date of the beneficiary's disenrollment from the employer/union sponsored MA plan.

Additionally, the information provided must include an explanation on how to contact Medicare for information about other MA plan options that might be available to the beneficiaries.

The employer/union must have and provide all the information required for the MA organization to submit a complete disenrollment request transaction to CMS, as described in this and other CMS MA systems guidance. Records must be maintained as outlined in §60.9 of this chapter.

50.1.7 - Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll from the MA plan and into Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that s/he disenrolled as a result of an SEP and is eligible for such guaranteed issue rights. A beneficiary may contact the MA organization for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

50.2 - Required Involuntary Disenrollment

The MA organization **must** disenroll a member from an MA plan in the following cases. Refer to §50.6 for some exceptions to required disenrollment for grandfathered members.

1. A change in residence (includes incarceration – see below) makes the individual ineligible to remain enrolled in the plan (§50.2.1);
2. The member loses entitlement to either Medicare Part A or Part B (§50.2.2.);
3. The SNP enrollee loses special needs status and does not reestablish SNP eligibility prior to the expiration of the period of deemed continued eligibility (§20.11).
4. The member dies (§50.2.3);
5. The MA organization contract is terminated, or the MA organization reduces its service area to exclude the member. There is an exception to this rule, which is described in §50.2.4; or
6. The member fails to pay his /her Part D-IRMAA to the government and CMS notifies the plan to effectuate the disenrollment (§50.2.6).

Incarceration – A member who is incarcerated is considered to be residing outside the plan's service area, even if the correctional facility is located within the plan's service area. However,

plans must disregard past periods of incarceration that have been served to completion if those periods have not already been addressed by a plan or by CMS (see §50.2.1.3 below).

Notice Requirements - In situations where the MA organization disenrolls the member involuntarily on any basis except death, loss of entitlement or failure to pay Part D-IRMAA, notices of the upcoming disenrollment meeting the following requirements must be sent. All disenrollment notices must:

1. Advise the member that the MA organization is planning to disenroll the member and why such action is occurring;

2. Be mailed to the member before submission of the disenrollment transaction to CMS; and

3. Include an explanation of the member's right to a hearing under the MA organization's grievance procedures. (This explanation is not required if the disenrollment is a result of the MA plan termination or service area or continuation area reduction, since a hearing would not be appropriate for that type of disenrollment. There are different notice requirements for terminations and service area reductions, which are provided in separate instructions to MA organizations.)

Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll to Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and are eligible for such guaranteed issue rights. A beneficiary may contact you for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

50.2.1 - Members Who Change Residence

MA organizations may offer (or continue to offer) extended "visitor" or "traveler" programs to members of coordinated care plans who have been out of the service area for up to 12 months. The MA organizations that offer such programs do not have to disenroll members in these extended programs who remain out of the service area for more than 6 months but less than 12 months. As mentioned at 42 CFR 422.74(d)(4)(iii), MA organizations offering a plan with a visitor/traveler program must make this option available to all enrollees who are absent for an extended period from the MA plan's service area. However, MA organizations may limit this option to enrollees who travel to certain areas, as defined by the MA organization, and who receive services from qualified providers. Organizations offering MA-PFFS plans may allow continued enrollment of individuals absent from the plan service area for up to 12 months, given that PFFS plans provide access to plan benefits and services from providers located outside the plan service area.

MA organizations offering plans without these programs must disenroll members who have been out of the service area for more than 6 months.

An SEP, as defined in §30.4.1, applies to individuals who are disenrolled due to a change in residence. An individual may choose another MA or Part D plan (either a PDP or MA-PD) during this SEP.

50.2.1.1 - General Rule

The MA organization must disenroll a member if:

1. He/she permanently moves out of the service area and his/her new residence is not in a continuation area;

2. The member's temporary absence from the service area (or continuation area, for continuation of enrollment members) exceeds 6 consecutive months;

3. The member is enrolled in an MA plan that offers a visitor/traveler program and his/her temporary absence exceeds 12 consecutive months (or the length of the visitor/traveler program if less than 12 months);

4. The member is an out-of-area member (as defined in §10), and permanently moves to an area that is not in the service area or continuation area;

5. He/she permanently moves out of the continuation area of an MA local plan and his/her new residence is not in the service area or another continuation area of the MA local plan;

6. The member permanently moves out of the service area (or continuation area, for continuation of enrollment members in MA local plans) and into a continuation area, but chooses not to continue enrollment in the MA local plan (refer to §60.7 for procedures for choosing the continuation of enrollment option);

7. The member is an out-of-area member (as defined in §10), who leaves his/her residence for more than 6 months;

8. The member is incarcerated and, therefore, out of area.

50.2.1.2 - Effective Date

Generally disenrollments for **reasons 1, 4, 5, 6 and 8** above are effective the first day of the calendar month after the date the member begins residing outside of the MA plan's service area (or continuation area, as appropriate) AND after the member or his/her legal representative notifies the organization that s/he has moved and no longer resides in the plan service area. In the case of an individual who provides advance notice of the move, the disenrollment will be the first of the month following the month in which the individual indicates he/she will be moving. In the case of incarcerated individuals, MA organizations may receive notification of the individual's out-of-area status via a TRR; disenrollment is effective the first of the month following the organization's confirmation of a current incarceration. If the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the 1st of the month after the move), the MA organization can submit this request to CMS (or its designee) for consideration of retroactive action.

Disenrollment for **reasons 2 and 7** above is effective the first day of the calendar month after 6 months have passed. Disenrollment for **reason 3** is effective the 1st day of the 13th month (or the length of the visitor/traveler program if less than 12 months) after the individual left the service area.

Unless the member elects another Medicare managed care plan during an applicable election period, any disenrollment processed under these provisions will result in a change to enrollment in Original Medicare.

50.2.1.3 - Researching and Acting on a Change of Address

Within ten calendar days of receiving a notice of a change of address or an indication of possible out-of-area residency from the member, the member's legal representative, a CMS TRR, or another source, the MA organization must make an attempt to contact the member to confirm whether the move is permanent (may use Exhibit 34 if contacting the member in writing). The MA organization must also document its efforts. The requirement to attempt to contact the member does not apply to a prospective enrollment for which the organization receives either transaction reply code 011 (Enrollment Accepted) or 100 (PBP Change Accepted as Submitted) accompanied by 016 (Enrollment Accepted – Out of Area) on the same TRR, as these represent new enrollments for which the organization recently confirmed the individual's permanent residence in the plan service area. In the case of incarcerated individuals, the MA organization is not required to contact the individual but must confirm the individual's out-of-area (e.g. incarcerated) status. MA organizations may obtain either written or verbal verification of changes in address, as long as the MA organization applies the policy consistently among all members. When an organization is notified of a current member's past period of incarceration and has confirmed that this member's period of incarceration has ended (i.e. individual is no longer incarcerated), the organization must continue the individual's enrollment, unless otherwise directed by CMS.

If the MA organization confirms an individual's current incarceration status but does not obtain the start date of the current incarceration, the organization must disenroll the individual prospectively for the first of the month following the date on which the current incarceration was confirmed. If the MA organization confirms an individual's current incarceration status as well as the start date of the current incarceration, the organization must disenroll the individual for the first of the month following the start date of the incarceration. If that disenrollment effective date is outside the range of effective dates allowed by MARx (based on the current calendar month), the MA organization must submit the retroactive disenrollment request to the CMS Retroactive Processing Contractor (see §60.5).

The MA organization must retain documentation from the member or member's legal representative of the notice of the change in address, including the determination of whether the member's out-of-area status is temporary or permanent.

1. If the MA organization receives notice of a **permanent change** in address **from the member or the member's legal representative**, and the new address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), the MA organization must disenroll the member and provide proper notification (Exhibit 36). The only exception is if the member has permanently moved into the continuation area and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.8).

2. If the MA organization receives notice (or indication) of a potential change in address **from a source other than the member or the member's legal representative**, and the new address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), the MA organization may not assume the move is permanent until it has received confirmation from the member, the member's legal representative or, for incarcerated individuals, public sources (such as a state/federal government entity or other public records).

   The MA organization must initiate disenrollment when it verifies a move is permanent or when the member has been out of the service area (or continuation area, for continuation of enrollment members) for six months from the date the MA organization learned of the change in address. The MA organization must notify the member in writing of the disenrollment. If the member responded and confirmed the permanent move out of the service area, the MA organization must send the notice (Exhibit 36) within 10 calendar days of the member's confirmation that the move is permanent. If the member failed to respond to the request for address confirmation the MA organization must send the notice (Exhibit 35) in the first ten days of the sixth month from the date the MA organization learned of the change in address.

   MA organizations may consider the six months to have begun on the date given by the beneficiary as the date that he/she will be leaving the service area. If the beneficiary did not inform the MA organization of when he/she left the service area, the MA organization can consider the six months to have begun on the date it received information regarding the member's potential change in address (e.g. TRR, out-of-area claims).

   If the member does not respond to the request for verification within the time frame given by the MA organization, the MA organization cannot assume the move is permanent and may not disenroll the member until six months have passed. The MA organization may continue its attempts to verify address information with the member.

3. **Temporary absences -** If the MA organization determines the change in address is temporary, the MA organization may not initiate disenrollment until six months have passed from the date the MA organization received information regarding the member's absence from the service area (or from the date the member states that his/her address changed, if that date is earlier).

   If the MA organization offers a visitor/traveler program, the MA organization must initiate disenrollment if it learns that the individual continues to remain out of the service area during the 12 months (or the length of its visitor/traveler program if less than 12 months).

50.2.1.4 - Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable

If an address is not current, the USPS will return any materials mailed first-class by the organization as undeliverable.

In the event that any member materials are returned as undeliverable, the organization must take the following steps:

1. If the USPS returns mail with a new forwarding address, forward plan materials to the beneficiary and advise the plan member to change his or her address with the Social Security Administration.
2. If the organization receives documented proof of a beneficiary change that is outside of the plan service area or mail is returned without a forwarding address, follow the procedures described in §50.2.1.3.
3. If the organization receives claims for services from providers located outside the plan service area, the organization may choose to follow up with the provider to obtain the member's address.
4. If the organization is successful in locating the beneficiary, advise the beneficiary to update records with the Social Security Administration by:

    a. Calling their toll-free number, 1-800-772-1213. TTY users should call 1-800-325-0778 weekdays from 7:00 a.m. to 7:00 p.m. EST;
    b. Going to http://www.ssa.gov/changeaddress.html on the SSA website; or
    c. Notifying the local SSA field office. A beneficiary can get addresses and directions to SSA field offices from the Social Security Office Locator which is available on the Internet at: http://www.socialsecurity.gov/locator/.

An organization is expected to continue to mail ~~beneficiary~~ materials to the *member's address of record*~~*undeliverable address*~~*. If the postal service returns a piece of beneficiary communication to the organization, the plan should document the return and retain the returned material. It should continue to send future correspondence to that same address*, as a forwarding address may become available at a later date*. Additionally, CMS encourages the MA organization*~~*, and is encouraged*~~ to continue its efforts, as discussed above, to attempt to locate the beneficiary using any available resources, including CMS systems, to identify new address information for the beneficiary. If a forwarding address becomes available, an organization can send materials to that address as in item #1 above.

50.2.1.5 - Notice Requirements

1. **MA organization notified of out-of-area permanent move -** When the organization receives notice of a permanent change in address from the member or the member's legal representative, it must provide notification of disenrollment to the member. This notice to the member, as well as the disenrollment transaction to CMS, must be sent within 10 calendar days of the MA organization's learning of the permanent move.

    In the notice, the MA organization is encouraged to inform the member who moves out of the service area that he/she may have certain Medigap enrollment opportunities available to them. These opportunities end 63 days after coverage with the MA organization ends. The MA organization can direct the beneficiary to contact the State Health Insurance Assistance Program (SHIP) for additional information on Medigap insurance.

2. **Out of area for 6 months -** When the member has been out of the service area for 6 months after the date the MA organization learned of the change in address from a source

other than the member or the member's legal representative (or the date the member stated that his address changed, if that date is earlier), the MA organization must provide notification of the upcoming disenrollment to the member. Organizations are encouraged to follow up with members and to issue interim notices prior to the expiration of the 6 month period.

The notice of disenrollment must be provided within the first ten calendar days of the sixth month. The transaction to CMS must be sent within 3 business days following the disenrollment effective date.

This notice must also be provided to out-of-area members (as defined in §10) who leave their residence and that absence exceeds six months.

The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

EXAMPLE

MA organization receives a TRR on January 20 indicating an "out of area" State and County Code. The 6-month period ends on July 20. The MA organization sends a notice to the member within 10 calendar days of receipt of the TRR and does not receive any response from the member indicating this information is incorrect. Therefore, the MA organization will proceed with the disenrollment, effective August 1. The MA organization sends a notice to the member during the first 10 calendar days of July notifying him that he will be disenrolled effective August 1. The transaction to CMS must be sent no later than 3 business days following July 31.

3. **Visitor/Traveler Program Option -** When the member has been out of the service area for 12 months (or the length of its visitor/traveler program if less than 12 months), the MA organization must provide notification of the upcoming disenrollment to the member.

   The notice of disenrollment must be provided during the first ten calendar days of the 12th month (or the length of its visitor/traveler program). The transaction to CMS must be sent within 3 business days following the disenrollment effective date.

   The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

50.2.2 - Loss of Medicare Part A or Part B

With the exception of Medicare Part B-only grandfathered members (as described in §§20.6 and 50.6), the MA organization cannot retain a member in an MA plan if the member is no longer entitled to both Medicare Part A and Part B benefits. The organization will be notified by CMS that entitlement to either Medicare Part A or Part B has ended, and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to either Medicare Part A or Part B benefits (whichever occurred first).

If a member loses entitlement to Medicare Part A, the MA organization may not allow the member to remain a member of the plan and receive Medicare Part B-only services. In addition, the MA organization may not offer Part A-equivalent benefits and charge a premium for such coverage to members who lose entitlement to Medicare Part A. Likewise, if a member loses entitlement to Medicare Part B at any time, the MA organization may not allow the member to remain in the MA plan.

Notice Requirements - CMS strongly suggests that notices be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see Exhibit 14) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

50.2.3 - Death

The CMS will disenroll a member from an MA organization upon his/her death and CMS will notify the MA organization that the member has died. This disenrollment is effective the first day of the calendar month following the month of death. Organizations may not submit disenrollment transactions to CMS in response to the apparent death of a member. If the eligibility query shows a date of death, the MA organization must submit the enrollment only when the date of death is equal to or greater than the effective date. In anticipation of official notification from CMS via the TRR, organizations may, at their discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices.

Notice Requirements – Following receipt of a CMS notification (via TRR) of disenrollment due to death, CMS strongly suggests that a notice be sent to the member or the estate of the member (see Exhibit 13) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

50.2.4 - Terminations/Nonrenewals

The MA organization must disenroll a member from an MA plan if the MA organization contract is terminated or if the MA organization discontinues offering the plan or reduces its service area to exclude the member.

A member who is disenrolled under these provisions has an SEP, as described in §30.4.3, to elect a different MA plan or Original Medicare. A member who fails to make an enrollment request during this SEP is deemed to have elected Original Medicare.

EXCEPTION

MA organizations can offer an option to continue enrollment in an MA local plan in the organization to members affected by MA plan service area reductions in areas where no other MA plans are available at that time. If the organization chooses to offer this option, it must notify CMS, and must notify members in the beneficiary non-renewal notification letter.

Members must indicate their desire to take advantage of this option. Members who take this option to continue enrollment become known as “out-of-area members,” as defined in §10. The organization may require individuals who choose to continue enrollment in an MA local plan in the organization to agree to receive the full range of basic benefits (excluding emergency and urgently needed care, renal dialysis, and post stabilization) exclusively at facilities designated by the MA organization within the MA local plan service area.

Notice Requirements - The MA organization must give each Medicare member a written notice of the effective date of the termination or service area or continuation area reduction, and include a description of alternatives for obtaining benefits under the Medicare program. Required time frames for these notices are outlined in
42 CFR 422.506 - 422.512.

50.2.5 – Loss of Special Needs Status

A SNP must continue to provide care for at least one full calendar month for a member who no longer has special needs status, as long as the plan can provide appropriate care and the individual can reasonably be expected to again meet the special needs criteria within six (6) months. For example, a dual eligible individual who loses Medicaid eligibility can be deemed to continue to be eligible for the plan if that individual would likely regain eligibility within six months. The SNP may choose any length of time from one month to six months for deeming continued eligibility, as long as it applies the criteria consistently to all members of the plan and fully informs members of its policy. If the member of a SNP does not re-qualify within the plan's period of deemed continued eligibility, s/he must be involuntarily disenrolled from the plan, with proper notice, at the end of this period. The period of deemed continued eligibility begins the first of the month following the month in which information regarding the loss is available to the organization and communicated to the enrollee, including cases of retroactive Medicaid terminations.

During the period of deemed continued eligibility the organization must continue to provide all plan benefits and must ensure that deemed-eligible members are not held liable for more than the plan premium and cost sharing amounts owed by members who have not lost special needs status. Also, the organization must continue coverage of any supplemental benefits (e.g., vision, dental, etc.) during this period.

If the SNP cannot provide continuity of care to a member who loses eligibility, the organization must involuntarily disenroll the member. For example, when a member of an institutional SNP leaves the long-term care facility, s/he must be disenrolled from that SNP if the SNP providers are limited to those within the facility. Regardless of the date on which the beneficiary loses special needs status, the organization must provide him/her with a minimum of 30 days advance notice of disenrollment.

Refer to Chapter 1 of the Medicare Managed Care Manual for additional information on Special Needs Plans.

Notice Requirements - The SNP must provide each member a written notice regarding the loss of special needs status within 10 calendar days of learning of the loss of special needs status. This notice must provide the member an opportunity to prove that s/he is still eligible to be in the plan. In addition, the notice must include information regarding the period of deemed continued eligibility, including its duration, a complete description of the SEP for which such individuals are eligible (see §30.4.4, item #10), the consequences of not regaining special needs status within the period of deemed continued eligibility and the effective disenrollment date (see Exhibit 32). Organizations are encouraged to follow up with members and to issue interim notices prior to the expiration of the period of deemed continued eligibility.

In the event the individual fails to regain special needs status during the period of deemed continued eligibility, the SNP must provide the individual a written notice regarding involuntary

disenrollment (see Exhibit 33) and must submit a disenrollment transaction to CMS. The disenrollment notice to the individual and the transaction to CMS must be sent within 3 business days following the last day of the period of deemed continued eligibility; however, in no case may the disenrollment notice to the individual be sent after the transaction is submitted to CMS.

In the event the SNP fails to process disenrollments timely, the organization must take the following action(s):

a. If the SNP has not provided timely notification to the member of the potential for involuntary disenrollment due to loss of special needs status (see Exhibit 32), the SNP must provide this notice to the member and must include a proposed disenrollment date that provides the member the full length of the period of deemed continued eligibility. The SNP may not shorten the grace period due its delay in issuing the notice.

b. If the SNP has not provided timely notification to the member of the involuntary disenrollment due to loss of special needs status (see Exhibit 33), the SNP must provide this notice to the member, must revise the disenrollment date accordingly and must include an explanation of the delay and of the revised disenrollment date.

50.2.6 – Failure to Pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Individuals with Part D-IRMAA must pay this additional premium directly to the government, not to their plans. CMS has established a 3-month initial grace period before individuals in an MA plan with Part D coverage (MA-PD) who fail to pay their assessed Part D-IRMAA will be disenrolled from the MA-PD plan. CMS will report the disenrollments to the organization via the daily TRR using a specific Transaction Reply Code (TRC). The effective date of the disenrollment is the first of the month following the end of the initial grace period.

Example: Ms. Jones owes a Part D-IRMAA. CMS bills Ms. Jones her monthly Part D-IRMAA amount in March, April and May. Ms. Jones does not pay all the Part D-IRMAA amounts owed by the due date of the May bill. CMS generates a disenrollment and sends the plan a specific TRC via the daily TRR. The effective date of the disenrollment will be June 1.

An MA organization must send each affected individual a written notice of the disenrollment within ten (10) calendar days of receipt of the TRR indicating disenrollment for non-payment of the Part D-IRMAA.

Note: CMS plans to begin disenrollments for failure to pay Part D-IRMAA in March, with an effective date of April 1, 2012.

Notice Requirements - MA organizations are required to notify members of their disenrollment due to failure to pay Part D-IRMAA (see Exhibit 21a.)

When an individual fails to pay both Part D-IRMAA and the plan premium, and the disenrollment effective dates are the same, the TRC for the disenrollment action will reflect the first disenrollment transaction that is processed by MARx. For example, if the plan-generated disenrollment transaction, resulting from the failure to pay plan premiums, is processed by MARx before CMS initiates a disenrollment transaction for failure to pay Part D-IRMAA, the

TRC will reflect the plan-generated disenrollment. Thus, plans would issue Exhibit 21 as outlined in Section 50.3 regarding notice requirements.

Similarly, if the CMS-generated disenrollment transaction for failure to pay Part D-IRMAA is processed first, plans will receive the TRC reflecting this action. In such cases, CMS will be unable to process the plan-generated disenrollment transaction (because the individual is already disenrolled), however, plans may review their own billing records to determine if an individual was slated for disenrollment for non-payment of plan premiums. If so, and the effective date of the disenrollment matches the Part D-IRMAA disenrollment effective date, plans have three options for notifying beneficiaries:

1. Plans may send the notice for failure to pay Part D-IRMAA (Exhibit 21a);
2. Plans may send both the notice for failure to pay Part D-IRMAA (Exhibit 21a) and the plan notice for failure to pay premiums (Exhibit 21); or
3. Plans may send the plan notice for failure to pay premiums and include information regarding the Part D-IRMAA disenrollment (Exhibit 21).

Reinstatement for "Good Cause" – Individuals involuntarily disenrolled from their MA-PD plan for failure to pay Part D-IRMAA have the opportunity to ask CMS for reinstatement into the plan from which they were disenrolled. CMS may reinstate enrollment, without interruption of coverage, if the individual demonstrates "good cause" and pays all Part D-IRMAA and plan owed amounts (both past due and monthly amounts during the request period) within 3 calendar months after the disenrollment effective date (see §60.3.4).

50.3 - Optional Involuntary Disenrollments

An MA organization may disenroll a member from an MA plan it offers if:

- Premiums are not paid on a timely basis (§50.3.1);
- The member engages in disruptive behavior (§50.3.2); or
- The member provides fraudulent information on an enrollment request, or if the member permits abuse of an enrollment card in the MA plan (§50.3.3).

Notice Requirements - In situations where the MA organization disenrolls the member involuntarily for any of the reasons addressed above, the MA organization must send notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that the MA organization is planning to disenroll the member and why such action is occurring;
- Provides the effective date of termination; and
- Includes an explanation of the member's right to a hearing under the MA organization's grievance procedures.

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

50.3.1 - Failure to Pay Premiums

MA organizations may not disenroll a member who fails to pay MA plan cost sharing under this provision. However, an MA organization has three options when a member fails to pay the MA plan's basic and supplementary premiums. This includes any Part D late enrollment penalty (per Chapter 4 of the Medicare Prescription Drug Benefit Manual).

For each of its MA plans (i.e. each PBP), the MA organization must take action consistently among all members of the discrete plan. For example, an MA organization may have different policies among each of its plans, but it may not have different policies within a plan (other than the optional exception for dual-eligible individuals and individuals who qualify for the Part D low income subsidy, as described below).

The MA organization **may**:

1. Do nothing, (i.e., allow the member to remain enrolled in the same premium plan);

2. Disenroll the member after a grace period and proper notice; or

3. If the member fails to pay the premium for optional supplemental benefits (that is, a package of benefits that the member is not required to accept), but pays the premium for basic and mandatory supplemental benefits, reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefits and retaining the member in the **same** plan after proper notice. Given these requirements for a downgrade, this option is available only for MA plans that have optional supplemental benefits offered at a higher premium than the basic benefit package. Such an action would be considered an addendum to the member's original request to enroll in the MA plan, and would not be considered a new enrollment request. Refer to Chapter 4 (Benefits and Beneficiary Protections) for a definition of "basic benefit," "mandatory supplement," and "optional supplemental benefits."

If an MA organization chooses to disenroll members for failure to pay premiums, it must apply its disenrollment policy consistently to all members of a plan including applying a consistent grace period of no less than two (2) months. Additionally, the organization must promptly effectuate such disenrollments at the end of the plan's grace period for payment of premiums.

The MA organization may increase the length of the initial grace period or establish a policy of not disenrolling members for failure to pay the plan premium during the calendar year. For example, an MA organization may increase the grace period from 2 months to 6 months to ease the burden for individuals affected by a natural disaster; however, it must provide this extended grace period to everyone in the PBP and not only those in the area affected by the natural disaster. An organization must report any changes to its policy for disenrollment for failure to pay premiums to its CMS account manager before implementing such changes.

If the MA organization chooses to disenroll the member or reduce coverage, the action may only be accomplished after the MA organization has made a reasonable effort to collect the premium and notice has been provided (as described below). If payment has not been received within the grace period, the individual will be disenrolled (or coverage reduced, as applicable).

Organizations **<u>may not</u>** disenroll members for failure to pay premiums (or notify them of impending disenrollment) in cases where the member has requested that premiums be withheld

from his/her Social Security benefit check until the organization receives a reply from CMS indicating that the member's request has been rejected. The organization must then notify the member of the premium owed, provide the appropriate grace period, and comply with other applicable requirements prior to disenrolling the member.

Organizations may not involuntarily disenroll individuals who are considered to be in premium withhold status by CMS. Individuals who have requested premium withhold are considered to remain in premium withhold status until either (1) CMS notifies the organization that the premium-withhold request has rejected, failed, or been unsuccessful; or (2) the member requests that he/she be billed directly. Only after one of these actions occurs may a member's status be changed to "direct bill." Once the member is considered to be in "direct bill" status, the organization must notify the member of the premium owed and provide the appropriate grace period, as described below. Organizations must always provide members the opportunity to pay premiums owed before initiating any disenrollment action.

However, even if a member's premium payment status has been changed to "direct bill," if the member can demonstrate that Social Security Administration (SSA) or the Railroad Retirement Board (RRB) has withheld Part C and/or Part D premiums during the coverage month(s) in question, the member will be considered to remain in premium withhold status. Such a member **cannot** be disenrolled for failure to pay his/her premium(s), whether or not the organization actually receives these premiums on a timely basis.

> **Example 1 – Incorrect Continuation of Premium Withhold:** Individual was enrolled in Plan A and selected premium withhold. Individual subsequently enrolls in Plan B and does not select premium withhold. Upon receiving a direct bill from Plan B, the individual provides Plan B with proof that a premium deduction continues from his SSA benefit check. Since the member provided Plan B with evidence that a premium amount is currently being deducted from his check, Plan B cannot initiate the process to disenroll the individual for failure to pay premiums. Plan B must work with CMS to obtain appropriate premium reimbursement.

Further, an individual will continue to be considered in premium withhold status if an organization is notified by CMS that the member's request for premium withholding is not successful as a result of systems/fund transfer issues between CMS and SSA or RRB, or between CMS and the organization. CMS recognizes that in some instances organizations have not received premium amounts in their monthly CMS plan payment for members who have elected SSA or RRB withholding; however, organizations cannot hold their members responsible for such issues, nor penalize them by attempting to disenroll them from their plan. Therefore, the organization **may not** initiate the billing (and subsequent disenrollment process, if necessary) until a member is in "direct bill" status.

> **Example 2 – Incorrect Data Due to Systems Miscommunication:** An individual requests premium withhold, and Plan A correctly submits the request to CMS. The transaction request is submitted successfully by CMS to SSA or RRB and the appropriate premium amount is deducted from the individual's SSA or RRB benefit check. However, due to a systems issue between CMS and SSA or RRB, the premium withhold data is not correctly reflected in CMS systems. Thus, CMS does not pay the correct premium amount to Plan A. Plan A must work with CMS to obtain appropriate premium reimbursement and may not initiate the disenrollment process for the individual for failure to pay premiums while the premium continues to be withheld.

In addition, organizations may not disenroll a member or initiate the disenrollment process if the organization has been notified that the Part D portion of the premium is being paid by a SPAP, or other payer, and the organization has not yet coordinated receipt of the premium payments with the SPAP or other payer (refer to §50.6 of Chapter 14 of the Medicare Prescription Drug Benefit Manual for additional information regarding coordination of premium payments).

While the MA organization may accept partial payments, it has the right to ask for full payment within the grace period. If the member does not pay the required amount within the grace period, the effective date of disenrollment or reduction in coverage is the first day of the month after the period ends. Unless the member elects another MA plan during an applicable election period, any disenrollment processed under these provisions will always result in a change of enrollment request to Original Medicare. **The MA organization has the right to take action to collect the unpaid premiums from the beneficiary at any point during or after this process.**

If a member is disenrolled for failure to pay premiums and attempts to re-enroll in the organization, the MA organization may require the individual to pay any outstanding premiums owed to the MA organization before considering the enrollment request to be "complete."

If the individual is involuntarily disenrolled for failure to pay premiums, in order to re-enroll in that plan, or to enroll in another plan, the individual must request enrollment during a valid period. Payment of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums. Likewise, disenrollment for failure to pay premiums does not, in itself, provide the beneficiary an opportunity (SEP) to enroll in a different MA plan.

Calculating the Grace Period

An MA organization must provide plan enrollees with a grace period of not less than 2 calendar months; however, it may provide a grace period that is longer than 2 calendar months, at its discretion (e.g. organizations may elect to provide a 3-month initial grace period to match the Part D-IRMAA initial grace period). The grace period must be a whole number of calendar months and cannot include fractions of months. The grace period cannot begin until the individual has been notified of (billed for) the actual premium amount due, with such notice/bill specifying the due date for that amount and providing an opportunity to pay. For new enrollees of an MA-PD plan, the MA organization must wait until notified by CMS of the actual Part D premium which the beneficiary is responsible for paying directly before the individual can be notified of/billed for the amount due; for these individuals, the due date cannot be until after the organization receives notification from CMS as to the beneficiary's premium and notifies the individual of the amount due. The grace period may begin no earlier than the first of the month for which the premium was unpaid.

MA organizations have the following options in calculating and applying the grace period. The organization must apply the same option for all members of a plan.

Option 1 - MA organizations may consider the grace period to end not less than 2 calendar months after the first day of the month for which premium is unpaid.

If the overdue premium and all other premiums that become due during the grace period (in accordance with the terms of the member's agreement with the MA organization) are not paid in full by the end of the grace period, the MA organization may terminate or reduce the member's coverage.

As mentioned previously, the individual must be notified of/billed for the actual premium amount due before the premium can be considered "unpaid." For new enrollees, at a minimum, this cannot occur until CMS notifies the organization of the total premium due from the individual. Upon CMS notification, the organization would notify the individual of the amount due, with a prospective due date.

Under this scenario, MA organizations are encouraged to send subsequent notices as reminders or to show that additional premiums are due. Subsequent notices, therefore, should determine the expiration date of the grace period by reference to this date. Notice requirements are summarized in this section under the heading "notice requirements."

> **Example A:** Plan XYZ has a 2-month grace period for premium payment. Plan member Mr. Stone's premium was due on February 1, 2009. He did not pay this premium and on February 7th, the MA organization sent an appropriate notice. Mr. Stone ignores this notice and any subsequent premium bills. The grace period is the months of February and March. If Mr. Stone does not pay his plan premium before the end of March, he will be disenrolled as of April 1, 2009.

> **Example B:** Plan QRS has a 3-month grace period for premium payment. Plan member Mrs. Monsoon's premium was due on July 1, 2009. She did not pay this premium and on July 6th, the MA organization sent an appropriate notice. Mrs. Monsoon ignores this notice and subsequent premium bills. The grace period is the months of July, August and September. If Mrs. Monsoon does not pay her owed premiums by the end of this period (September 30), she will be disenrolled effective October 1, 2009.

In short, the MA organization may require that the member pay the overdue premiums in full within the grace period, as well as all other payments becoming due within that period, in order to avoid disenrollment (or a reduction in coverage, where applicable). If the MA organization requires the member to make full payment within the grace period and pay all premiums falling due within that period; however, the MA organization must state so in its initial delinquency notice to the member.

Option 2 - MA organizations may use a "rollover" approach in applying the grace period.

Under this scenario, the grace period would begin on the first of the month for which the premium is unpaid, but if the member makes a premium payment within the grace period, the grace period stops and is revised to reflect the new disenrollment date, depending on the number of months for which premiums are received. The member would then have a new grace period beginning on the 1st day of the next month for which the premium is due. The subsequent notice also would have to be sent within 15 calendar days, as described below, of the next premium due date. This process continues until the member's balance for delinquent premiums is paid in full or until the grace period expires with no premium payments being made, at which time the MA organization may disenroll the member.

Organizations are not required to issue new notices each time the member submits a partial premium payment (i.e. less than one month's premium), since this would not result in a change in the proposed disenrollment date. However, since payment of at least one month's past-due premium causes the disenrollment date to "roll over" (i.e. move forward) commensurate with the number of month's premium received, organizations must issue a notice warning of the potential for involuntary disenrollment (see Exhibit 19) which includes the new disenrollment date whenever payment of at least one month's premium is received during the grace period. These

subsequent notices are required to be sent within 15 calendar days of the premium due date that follows receipt of the premium payment.

EXAMPLE

Plan WXY has decided to offer a 2 month grace period for non-payment of plan premiums and has chosen the "rollover" approach to calculating the grace period. A member fails to pay his January premium due January 1. The MA organization sends a notice to the member on January 7th stating that his coverage will be terminated if the outstanding premium is not paid within the grace period. The notice advises him that his termination date would be March 1. The member then pays the January premium, but does not pay the February premium. The grace period is recalculated to begin on the 1st of the next month for which the premium is unpaid (February 1). On February 9th the MA organization sends a notice to the member reflecting the new grace period and the new anticipated termination date of April 1st. The member pays off his balance in full before the grace period expires; therefore, the member's coverage in the MA plan remains intact.

Notice Requirements - If it is the MA organization's policy to disenroll the member or to reduce coverage when a member has not paid premiums, the MA organization must send an appropriate written notice of non-payment of premium to the member **within 15 calendar days** of the premium due date (see Exhibit 19).

The MA organization may send interim notices after the initial notice.

In addition to the notice requirements outlined in §50.3, this notice must:

- Alert the member that the premiums are delinquent;
- Provide the member with an explanation of disenrollment procedures advising the member that failure to pay the premiums within the grace period that began on the 1st of the month for which premium was unpaid will result in termination or reduction of MA coverage, whichever is appropriate according to the MA organization policy, and the proposed effective date of this action;
- Explain whether the MA organization requires full payment within the grace period (including the payment of all premiums falling due during the intervening days, when and as they become due, according to the terms of the membership agreement) in order to avoid termination of membership or reduction in benefits; and,
- Explain the implications of a reduction in coverage (e.g., description of lower level of benefits), if the MA organization policy is to reduce coverage for the nonpayment of optional supplemental benefit premiums.

If a notice is returned to the organization as undeliverable, the organization should immediately implement its procedure for researching a potential change of address (see §§50.2.1.3 and 50.2.1.4) as well. The beneficiary may have moved out of the service area. If the organization confirms the permanent move such that a disenrollment date earlier than the end of the grace period is required, the organization must disenroll the beneficiary for the earlier disenrollment date.

If a member does not pay within the grace period, and the MA organization's policy is to disenroll the member, the MA organization must notify the member in writing providing the effective date of the member's disenrollment (refer to Exhibit 20) and submit a disenrollment transaction to CMS. The disenrollment notice to the individual and the transaction to CMS must be sent within 3 business days following the last day of the grace period; however, in no case may the disenrollment notice to the individual be sent after the transaction is submitted to CMS. In the event the organization submits a disenrollment request to CMS and later learns that payment was received timely, a reinstatement request must be submitted to CMS (or its designee). In addition, CMS strongly encourages that MA organizations send final confirmation of disenrollment to the member after receiving the TRR (refer to Exhibit 21 for a model letter).

If a member does not pay within the grace period, and the MA organization policy is to reduce coverage by eliminating optional supplemental benefits within the current plan, for the nonpayment of optional supplemental benefit premiums, the MA organization must notify the member in writing no later than 3 business days after the expiration of the grace period that the MA organization is reducing the coverage and provide the effective date of the change in benefits (refer to Exhibit 22 for a model letter).

Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low Income Subsidy

MA organizations offering MA-PD plans have the **option** to retain dually eligible members and individuals who qualify for the low income subsidy (LIS) who fail to pay premiums even if the MA organization has a policy to disenroll members for non-payment of premiums. For MA-only plans, organizations may retain individuals who are dually eligible for both Medicare and Medicaid (i.e. individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program).

The MA organization has the discretion to offer this option to dually eligible individuals and individuals who qualify for LIS within each of its MA plans. If the MA organization offers this option in one of its plans, it must apply the policy to all such individuals in that MA plan.

The policy to retain individuals is based upon non-payment of premium for the standard benefit package of the MA plan. If the MA organization chooses this option, any dually eligible individual or individual who qualifies for LIS who fails to pay premiums for any optional supplemental benefit offered would be downgraded to the standard benefit package within that MA plan.

CMS requires that organizations provide members advance notice of plan policy changes. An MA organization will have the discretion as to how it will notify its members of the change, e.g. in an upcoming newsletter or other member mailing, such as the Annual Notice of Change. CMS recommends a general statement in such notifications to avoid confusing other members for whom the policy does not apply.

> **Example:** "If you have Medicaid or receive extra help in paying for your Medicare prescription drugs and are having difficulty paying your plan premiums or cost sharing, please contact us."

The plan must document this policy internally and have it available for CMS review.

50.3.2 - Disruptive Behavior

The MA organization **may** request to disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the MA plan substantially impairs the MA organization's ability to arrange for or provide services to either that particular member or other members of the plan. However, the MA organization may disenroll a member for disruptive behavior only after it has met the requirements of this section and with CMS' approval. The MA organization may not disenroll a member because he/she exercises the option to make treatment decisions with which the MA organization disagrees, including the option of no treatment and/or no diagnostic testing. The MA organization may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the MA organization or any health care professionals associated with the MA organization.

Before requesting CMS' approval of disenrollment for disruptive behavior, the MA organization must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The MA organization must also inform the individual of his or her right to use the organization's grievance procedures.

The MA organization must submit documentation of the specific case to CMS for review. This includes documentation:

- Of the disruptive behavior;
- Of the MA organization's serious efforts to resolve the problem with the individual;
- Of the MA organization's effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances cited under 42 CFR 422.74(d)(2)(iii) and (iv);
- That the MA organization provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and
- That the MA organization then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).

The MA organization must submit to its CMS Regional Office account manager:

- The above documentation;
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the MA organization's ability to arrange for or provide services to the individual or other members of the MA plan;

- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;

- Statements from providers describing their experiences with the member; and

- Any information provided by the member.

The MA organization may request that CMS consider prohibiting re-enrollment in the MA plan (or plans) offered by the MA organization in the service area.

The MA organization's request for involuntary disenrollment for disruptive behavior must be complete, as described above. The CMS Regional Office will review this documentation and consult with CMS Central Office (CO), including staff with appropriate clinical or medical expertise, and decide whether the organization may involuntarily disenroll the member. Such review will include any documentation or information provided either by the organization and the member (information provided by the member must be forwarded by the organization to the CMS RO). CMS will make the decision within 20 business days after receipt of all the information required to complete its review. The CMS will notify the MA organization within 5 (five) business days after making its decision.

The Regional Office will obtain Central Office concurrence before approving an involuntary disenrollment. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment, or as provided by CMS. Any disenrollment processed under these provisions will always result in a change of enrollment request to Original Medicare.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the MA organization to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable accommodation in this context is that CMS could require the MA organization to delay the effective date of involuntary disenrollment to coordinate with an MA enrollment request or Part D enrollment period that would permit the individual an opportunity to obtain other coverage. If necessary, CMS will establish an SEP on a case-by-case basis.

Notice Requirements

The disenrollment for disruptive behavior process requires 3 (three) written notices:

- Advance notice to inform the member that the consequences of continued disruptive behavior will be disenrollment;

- Notice of intent to request CMS' permission to disenroll the member; and

- A planned action notice advising that CMS has approved the MA organization's request.

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the MA organization must provide the member with written notice describing the behavior it has identified as disruptive and how it has impacted the MA organization's ability to arrange for or provide services to the member or to other members of the MA plan. The notice must explain that his/her continued

behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action. The MA organization must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS. **NOTE:** If the disruptive behavior ceases after the member receives notice and then later resumes, the MA organization must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the MA organization's efforts, then the MA organization must notify him/her of its intent to request CMS' permission to disenroll him/her for disruptive behavior. This notice must also advise the member of his/her right to use the organization's grievance procedures and to submit any information or explanation. Refer to Chapter 13, "Grievances, Organizations Determinations, and Appeals," for the appropriate procedures for grievances. The MA organization must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS.

Planned Action Notice

If CMS permits an MA organization to disenroll a member for disruptive behavior, the MA organization must provide the member with a written notice that contains, in addition to the notice requirements outlined in §50.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above. The MA organization may only provide the member with this required notice after CMS notifies the MA organization of its approval of the request.

The MA organization can only submit the disenrollment transaction to CMS after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the MA organization gives the member a written notice of the disenrollment, or as provided by CMS.

50.3.3 - Fraud and Abuse

An MA organization **may** request to cancel the enrollment of a member who knowingly provides, on the enrollment request form or by another enrollment request mechanism, fraudulent information that materially affects the determination of an individual's eligibility to enroll in the plan. The organization may also request to disenroll a member who intentionally permits others to use his/her enrollment card to obtain services or supplies from the plan or any authorized plan provider. Such a disenrollment is effective the first day of the calendar month after the month in which the organization gives the member the written notice.

When such a cancellation or disenrollment occurs, the organization must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse. Any disenrollment processed under these provisions will always result in a change of enrollment to Original Medicare.

Notice Requirements - The MA organization must give the member a written notice of the disenrollment that contains the information required at §50.3.

50.4 - Processing Disenrollments

50.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from a member, the MA organization is responsible for submitting the disenrollment transaction to CMS in a timely, accurate fashion. Such transmissions must occur within 7 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The MA organization must maintain a system for receiving, controlling, and processing voluntary disenrollments from the MA organization. This system should include:

- Dating each disenrollment request as of the date it is received (regardless of whether the request is complete at the time it is received by the MA organization) to establish the date of receipt;

- Dating supporting documents for disenrollment requests as of the date they are received;

- Processing disenrollment requests in chronological order by date of receipt of completed disenrollment requests;

- Transmitting disenrollment information to CMS within 7 calendar days of the receipt of the completed disenrollment request from the individual or the employer or union (whichever applies). If the disenrollment information is received through the employer or union, the MA organization must obtain the member's written disenrollment request from the employer or union;

- For disenrollment requests received by the MA organization, notifying the member in writing within ten calendar days after receiving the member's written request, to acknowledge receipt of the completed disenrollment request, and to provide the effective date (see Exhibit 11 for a model letter). MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the TRR;

- For all other voluntary disenrollments (i.e., voluntary disenrollments made by the beneficiary through 1-800-MEDICARE, or by enrolling in another MA plan or PDP, which the MA organization would not learn of until receiving the TRR), notifying the member in writing to confirm the effective date of disenrollment within ten calendar days of the availability of the TRR (see Exhibit 12 for a model letter). This notice requirement does not apply to a disenrollment resulting from a member switching from one benefit package to another within the same organization (i.e., a PBP change).

50.4.2 – When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete, the MA organization must document all efforts to obtain additional documentation to complete the disenrollment request and have an audit trail to document why additional documentation was needed before the request could be considered complete. The organization must make this determination, and within 10 calendar days of receipt of the disenrollment request, must notify the individual that additional information is needed.

If a written disenrollment request is submitted and the signature is not included, the MA organization may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

For AEP disenrollment requests, additional documentation to make the request complete must be received by December 7, or within 21 calendar days of the request for additional information (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the disenrollment request was initially received, or within 21 calendar days of the request for additional information (whichever is later).

50.4.3 - Involuntary Disenrollments

The MA organization is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The MA organization must maintain a system for controlling and processing involuntary disenrollments from the MA organization. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member; and

- For all involuntary disenrollments except disenrollments due to death and loss of Medicare Parts A and/or B, notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights.

In addition, CMS strongly encourages MA organizations to send confirmation of involuntary disenrollment to ensure the member discontinues use of MA organization services after the disenrollment date.

50.5 - Disenrollments Not Legally Valid

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §60.3 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (as stated in §50.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete, as defined in §10, is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

The CMS also does not regard a voluntary disenrollment as actually complete if the member or his/her legal representative did not intend to disenroll from the MA organization. If there is evidence that the member did not intend to disenroll from the MA organization, the MA organization should submit a reinstatement request to CMS (or its designee). Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or

- Request by the member for cancellation of disenrollment before the effective date (refer to §60.2 for procedures for processing cancellations).

Discontinuation of payment of premiums alone does not necessarily indicate that the member has made an informed decision to disenroll.

In contrast, CMS believes that a member's deliberate attempt to disenroll from a plan (e.g. sending a written request for disenrollment to the MA organization, or calling 1-800-MEDICARE) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

50.6 - Disenrollment of Grandfathered Members

As discussed in §20.6, any individual who was enrolled in a §1876 risk plan effective December 1, 1998, or earlier, and remained enrolled with the risk plan on December 31, 1998, automatically continued to be enrolled in the MA organization on January 1, 1999, even if he/she was not entitled to Medicare Part A or did not live in an MA plan service area or MA organization continuation area.

Disenrollment procedures for grandfathered members are generally the same as those for other members. The MA organization must disenroll any grandfathered member if:

- The member dies;

- The member loses either Medicare Part A or Part B (or for Part B only members, enrollment in Medicare Part B ends for the member);

- The member permanently moves into the continuation area, but does not choose to continue enrollment or moves to an area that is out of the service or continuation area;

- The member permanently moves out of the vicinity, making continued enrollment no longer reasonable. For example, a move of only a short distance may not affect the member's ability to continue to access the plan; therefore, continued enrollment would be reasonable; or,

- The MA organization contract is terminated or the service area or continuation area is reduced with respect to all MA individuals who live in the area where the individual resides.

  NOTE: The member may be offered the option to continue enrollment, as described in §50.2.4.

50.7 - Disenrollment Procedures for Employer/Union Sponsored Coverage Terminations

When the contract between an employer or union group and an MA organization is terminated, or the employer/union determines that a beneficiary is no longer eligible to participate in the employer/union sponsored MA plan[2], the MA organization has the option to follow one of two procedures to disenroll beneficiaries from the current employer/union sponsored MA plan in which the individual is enrolled:

For both of the following options, the MA organization must ensure that the employer or union agrees to the following:

- The employer or union will provide the MA organization with timely notice of contract termination or the ineligibility of an individual to participate in the employer or union group sponsored MA plan. Such notice must be prospective, not retroactive.

- The employer or union must provide a prospective notice to its members alerting them of the termination event and of other insurance options that may be available to them through their employer or union.

Option 1: Enroll the individual(s) in another MA plan (i.e. individual plan) offered by the same MA organization unless the beneficiary makes another choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area. The individual plan selected for this option must be the same type of plan. For example, if the employer/union sponsored plan was an MA-PD coordinated care plan, the individual plan in this option must be an MA-PD coordinated care plan.

- Beneficiaries may elect another MA plan offered by the employer or union, join Original Medicare or join another MA plan as an individual member instead of electing the individual MA plan offered by the same MA organization.

    - If the beneficiary prefers not to be enrolled in the individual plan, s/he may contact the MA organization.

    - If the beneficiary would prefer enrolling in a different MA plan as an individual member, he/she must submit an enrollment request to his/her newly chosen MA organization.

- If the individual takes no other action, he/she will become a member of the individual plan offered by the same MA organization that offered the employer/union sponsored plan.

- **MA Notice requirements** - The MA organization (or the employer or union, acting on its behalf) must provide <u>prospective</u> notice to the beneficiary that his/her plan is changing, including information about benefits, premiums, and/or copayments, at least 21 calendar days prior to the effective date of enrollment in the individual plan.

[2] The employer/union establishes criteria for its retirees to participate in the employer/union sponsored MA plan. These criteria are exclusive of and in addition to the eligibility criteria for MA enrollment. Eligibility criteria to participate and receive employer/union sponsored benefits may include spouse/family status, payment to the employer/union of the individual's part of the premium, or other criteria determined by the employer/union.

Option 2: Disenroll individual(s) from the employer/union sponsored MA plan to Original Medicare following prospective notice.

- **MA Notice requirements -** The MA organization (or the employer or union, acting on its behalf) must provide prospective notice to the beneficiary that his/her plan enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about other individual plan options the beneficiary may choose and how to request enrollment.

- If the employer/union sponsored plan was an MA-PD plan, the individual must be advised that the disenrollment action means the individual will not have Medicare drug coverage. Notice must include information about the potential for late-enrollment penalties that may apply in the future.

The MA organization must outline in its written policies and procedures the option(s) it follows and must apply the same option for all members of a particular employer/union sponsored plan. It is the MA organization's responsibility to ensure that the required elements of the disenrollment procedures described above are understood by the employer or union and are part of the agreement with each employer or union, including contract termination notification requirements.

50.8 - Disenrollment Procedures for Medicare MSA Plans

Members of Medicare MSA plans may only disenroll in writing through the MA organization offering the Medicare MSA plan; they may not disenroll through 1-800-MEDICARE. Election periods and effective dates for disenrollment from Medicare MSA plans are outlined in §30.7.

MA organizations offering Medicare MSA plans must otherwise follow the disenrollment policies and procedures outlined in §§50.2 through 50.5.

60 - Post-Enrollment Activities

42 CFR 60 & 422.66

Post-enrollment activities begin after the MA organization receives the enrollment request from the individual (e.g., cancellations) and last until a decision is made with respect to an individual's enrollment request (e.g., retroactive transactions).

60.1 - Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment request for the same individual with the same effective date in the same reporting period. An individual may generally not be enrolled in more than one MA, cost, HCPP or PDP plan at any given time (however, an individual may be simultaneously enrolled in a cost plan and a separate PDP plan or in certain MA plan types and a separate PDP plan).

Generally, the last enrollment request the beneficiary makes during an enrollment period will be accepted as the plan into which the individual intends to enroll. If an individual elects more than one plan for the same effective date and with the same application date, the first transaction successfully processed by CMS will take effect. Because simultaneous enrollment in certain MA plan types and a separate PDP is permitted, CMS systems will accept both enrollments.

Generally, given the use of the application date to determine the intended enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because the enrollment requests have the same application date.

EXAMPLES

- Two MA organizations receive enrollment forms from one individual. MAO #1 receives a form on March 4th and MAO #2 receives a form on March 10. Both organizations submit enrollment transactions, including the applicable effective date and application date. The enrollment in MAO #2 will be the transaction that is accepted and will be effective on April 1 because the application date on the enrollment transaction is the later of the 2 submitted. Both plans receive the appropriate reply on the TRR.

- Two MA organizations (MAOs) receive enrollment requests from one individual for an April 1 effective date. MAO #1 receives a paper enrollment form with all required information on March 5th. The beneficiary completed an enrollment request for MAO #2 by telephone on the same day, March 5th. Both enrollment requests have the same application date, since they were received by the MAO on the same date. Both enrollments were submitted to CMS prior to the April cut-off date. MAO #1 transmitted the enrollment to CMS on March 5th, the day it received the enrollment request; however, MAO #2 waited until March 8th to transmit the enrollment to CMS. The enrollment for MAO #1 will be the transaction that is effective on April 1, as it was the first transaction successfully processed by CMS.

In the event a rejection for a multiple transaction is reported to the MA organization, the organization may contact the individual. If the individual wishes to enroll in a plan offered by the organization that received the multiple transaction reject, s/he must submit a new enrollment request during a valid enrollment period.

60.2 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment made by an individual and/or mistaken disenrollment made by a member. Unless otherwise directed by CMS, an individual may cancel his/her enrollment (or disenrollment) request only by contacting the organization prior to the effective date of the enrollment (or disenrollment). For enrollments into employer or union sponsored plans, cancellations received by the employer or union prior to the enrollment effective date are also acceptable.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary. Refer to §§60.3 and 60.5.

If a beneficiary verbally requests a cancellation, the MA organization should document the request. MA organizations have the right to request that a cancellation be in writing. However, they may not delay processing of a cancellation until the request is made in writing if they have already received a verbal cancellation request from the beneficiary.

For facilitated enrollment as described in §40.1.5 of this chapter, a beneficiary may cancel the enrollment and affirmatively decline Part D benefits by telephone. The MA organization may not require these cancellations in writing.

60.2.1 - Cancellation of Enrollment

An individual's enrollment request can be cancelled only if the cancellation request is received by the organization prior to the effective date of the enrollment via phone, in writing or in person, unless otherwise directed by CMS.

To ensure the cancellation is honored, the MA organization should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment by the time it receives the valid request for cancellation, it must submit a cancellation transaction to CMS to cancel the now-void enrollment transaction. In the event the cancellation transaction fails or the MA organization has other difficulty, the MA organization must submit the request to cancel the action to the CMS Retroactive Processing Contractor in order to cancel the enrollment.

When canceling an enrollment transaction, the MA organization must send a letter to the individual that states that the cancellation is being processed (see Exhibit 25). This notice should be sent within ten calendar days of receipt of the cancellation request. This notice must inform the member that the cancellation should result in the individual remaining enrolled in the health plan in which he/she was originally enrolled, so long as the individual remains eligible to be enrolled in that health plan.

An MA organization may submit a transaction to cancel only those enrollment transactions it submitted. To cancel an enrollment, the MA organization must submit an enrollment cancellation transaction (transaction code 80) with an effective date equal to the effective date of the enrollment being cancelled..

If the member's request for cancellation occurs after the effective date of the enrollment, the cancellation generally cannot be processed. (An exception to this is a cancellation requested during the Outbound Education and Verification (OEV) process.) The organization must inform the beneficiary that he/she is a member of its MA plan. If he/she wants to return to the other MA

plan he/she will have to submit an enrollment request during a valid election period for a prospective enrollment effective date.

If the member wants to return to Original Medicare instead of returning to his/her previous plan, the member must be instructed to disenroll from the previous plan as described in §50.1 of this chapter. The member must be informed that the disenrollment must be made during an election period (described in §30.5) and will have a current effective date (as prescribed in §30.5), and must be instructed to continue to use plan services until the disenrollment goes into effect.

Regardless of the plan personnel receiving the request, the plan must document all contact with the beneficiary associated with the cancellation request.

When an organization receives notification of an individual's reinstatement, the organization has ten (10) calendar days to send the individual a notice of reinstatement (Exhibit 25a).

CANCELLATION OF MEDICARE MSA ENROLLMENT REQUEST:

An individual who elects a Medicare MSA plan during an AEP, and who has never before enrolled in a Medicare MSA plan, may revoke (i.e., "cancel") that enrollment request, preferably by December 7 (but law allows beneficiaries to do so by December 15) of the year in which s/he requested enrollment in the Medicare MSA plan. This cancellation will ensure the enrollment request does not go into effect on January 1. After December 7 and up to December 15, the beneficiary may only return to Original Medicare and cannot enroll into another MA plan or into a stand-alone PDP.

60.2.2 - Cancellation of Disenrollment

A member's disenrollment can be canceled only if the request is made prior to the effective date of the disenrollment, unless otherwise directed by CMS.

To ensure the cancellation is honored, the MA organization should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, it must submit a cancellation of disenrollment transaction, transaction code 81, to CMS to cancel the now-void disenrollment transaction. In the event the MA organization has submitted the disenrollment and is unable to submit the transaction code 81, or has other difficulty, the organization should submit the request to cancel the action to the CMS Retroactive Processing Contractor in order to cancel the disenrollment.

An MA organization may submit a transaction to cancel only those disenrollment transactions it submitted. To submit an action to cancel a disenrollment, the MA organization must submit a transaction code 81 (cancellation of disenrollment), with the effective date equal to the effective date of the disenrollment being cancelled.

The MA organization must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using MA plan services (see Exhibit 26). This notice should be sent within ten calendar days of receipt of the cancellation request.

Within ten (10) calendar days of receipt of confirmation of the individual's reinstatement, the organization must send the member written notification of the reinstatement (Exhibit 25a).

If the member's request for cancellation occurs after the effective date of the disenrollment, the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §60.3.2. If a reinstatement will not be allowed, the MA organization should instruct the member to submit a new enrollment request during a valid election period (described in §30), and with a current effective date, as prescribed in §30.5.

60.2.3 – When A Cancellation Transaction is Rejected by CMS Systems (Transaction Reply Code (TRC) 284)

When an MA organization receives a TRC 284 (Cancellation Rejected), while the cancellation remains valid, it could not be processed automatically in CMS' systems. The MA organization must investigate the circumstances behind the rejection. If the rejection was due to incorrect data on the transaction, the MA organization must correct the data and resubmit it to CMS. If the rejection was not due to such an error, and the request to cancel is valid, the MA organization must promptly submit the request to CMS (or its designee) for resolution.

60.3 - Reinstatements

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §50.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are:

1. Disenrollment due to erroneous death indicator;

2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator;

3. Reinstatements Based on Beneficiary Cancellation of New Enrollment;

4. Plan error; and

5. Demonstration of "good cause" for failure to pay premiums (plan and/or Part D-IRMAA) timely.

When a disenrolled individual contacts the MA organization to state that he/she was disenrolled due to items 1, 2 or 4 listed above, and states that he/she wants to remain a member of the MA plan, the MA organization must instruct the member in writing to continue to use MA plan services (refer to Exhibits 15, 16 and 17). The MA organization must send the notice within ten (10) calendar days of the individual's contact with the organization to report the erroneous disenrollment. Accordingly, plan systems should indicate active membership as of the date the organization instructs the individual to continue to use plan services.

When a disenrolled individual contacts the MA organization about either item 3 (reinstatement based on enrollment cancellation) or 5 ("good cause"), plans should follow the guidance outlined below pertaining to those unique situations.

A reinstatement is viewed as a correction necessary to "erase" an invalid disenrollment action, and, as such, does not require an election period. Therefore, reinstatements may be made back to a date when an MA plan was closed for enrollment. Payment alone of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums.

CMS (or its designee) will review requests for reinstatements on a case-by-case basis.

Within ten (10) calendar days of receipt of TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

60.3.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Medicare Part A or Part B

A member must be reinstated if he/she was disenrolled due to an erroneous death indicator or erroneous loss of Part A or Part B, since he/she continues to be eligible. As outlined in 42 CFR 422.74(c), MA organizations have the option of sending notification of disenrollment due to death or loss of Part A or B to the beneficiary. The CMS strongly suggests that MA organizations send these notices, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibit 13 and Exhibit 14 for model letters. Although organizations may request that individuals provide evidence of Medicare entitlement by a particular date, erroneous disenrollments must be corrected and the corresponding reinstatements processed, regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of Medicare entitlement.

To request consideration for reinstatement following disenrollment due to erroneous death indicator or erroneous loss of Medicare Part A or Part B, the MA organization must submit to CMS (or its designee) a copy of the letter to the member informing him/her to continue to use MA plan services until the issue is resolved. The organization must indicate the date the letter was sent. Refer to model letters in Exhibits 15 and 16. Within ten (10) calendar days of receipt of TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

CMS will attempt to automatically reinstate beneficiaries that were auto-disenrolled by a report of date of death if there is a subsequent date of death correction that impacts the plan enrollment.

60.3.2 - Reinstatements Based on Beneficiary Cancellation of New Enrollment

As stated in §50.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who were automatically disenrolled because they enrolled in another plan but subsequently cancelled the enrollment in the new plan before the effective date.

In this situation, that is, if an individual has since changed his/her mind and wants to remain enrolled in the previous plan, the individual must cancel the enrollment into the new plan, as described in section 60.2.1. When a cancellation of enrollment in a new plan is properly made, the associated automatic disenrollment from the previous MA plan becomes invalid. Upon successful cancellation of enrollment in the new plan, CMS systems will attempt to automatically reinstate enrollment in the previous plan. Because this process is automatic, it is generally not necessary to request reinstatement via the Regional Office or Retroactive Processing Contractor. Within ten (10) days of receipt of TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

In cases where the valid cancellation request is not processed timely or CMS systems cannot complete the request, the new plan must submit a request to the Retroactive Processing Contractor to cancel the enrollment. This request will require complete documentation, including evidence that the beneficiary requested cancellation of enrollment in the new plan within required timeframes.

If the previous plan becomes aware of an unsuccessful reinstatement, the previous plan may contact a CMS Account Manager to investigate the issue with the new plan.

If the disenrolled individual contacts the previous plan requesting to remain a member of that plan, the MA organization should inform the individual that reinstatement of enrollment is an option only if the individual successfully cancels enrollment in the "new" plan; accordingly, the organization should refer the individual to the "new" plan to inquire about his or her options.

60.3.3 - Reinstatements Due to Mistaken Disenrollment Due to Plan Error

A disenrollment that is not the result of either a valid voluntary request or a valid circumstance that requires involuntary disenrollment is erroneous. When an erroneous disenrollment is the result of plan error, the plan must reinstate the individuals who were disenrolled.

In the case of an erroneous disenrollment by the organization that is a result of an error the part of the organization, the organization must restore the enrollment in its records. Additionally, the organization must cancel the disenrollment action from CMS's records, if the organization had previously submitted such a transaction to CMS. Organizations must use the disenrollment cancellation function to complete this action for effective dates within the parameters that CMS systems allow for such corrections. For effective dates outside these parameters, the organization must ~~*submit*~~ *process* the request ~~*to the organization's Regional Office Account Manager with*~~ *according to the guidance for processing retroactive enrollment and disenrollment requests including* full documentation and explanation *as required*~~*for review*~~. ~~If approved, the organization may manually complete appropriate corrections to CMS systems. The Account Manager will provide instructions as to how to complete that activity.~~

Within ten (10) days of receipt of TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

60.3.4 - Reinstatements Based on "Good Cause" Determination for Failure to Pay Plan Premiums or Part D-IRMAA

If an individual has been involuntarily disenrolled for failure to pay either plan premiums (under §50.3.1) or Part D-IRMAA (under §50.2.6), s/he may request reinstatement by CMS no later than 60 calendar days following the effective date of disenrollment. Reinstatement will occur only under the following circumstances:

1. Individual requests reinstatement with CMS within the first 60 days of disenrollment effective date;
2. CMS determines that the individual meets the criteria specified and receives a favorable determination by CMS;
3. Individual pays all owed plan premiums and/or Part D-IRMAA amounts in full within the three month grace period (both past due amounts and the premium amounts that accrue for the months during the request for reinstatement).

The timeframe for the good cause reinstatement process is three months from the effective date of disenrollment.

Reinstatement of enrollment for "good cause" is provided only in rare circumstances in which the beneficiary or his/her authorized representative was unable to make timely payment due to circumstances over which they had no control and they could not reasonably have been expected to foresee. Examples of circumstances that may constitute "good cause" include:

- Federal government error caused the payment to be missed or late;
- Prolonged illness, hospitalization or institutionalization of the beneficiary;
- Death or serious illness of spouse or other family member; or
- Loss of the beneficiary's home or severe impact by fire, or other exceptional circumstance outside the beneficiary's control (e.g. affected individual resides in a federal disaster area).

Examples of circumstances that would not constitute "good cause" include:

- Allegation that bills or warning notices were not received due to unreported change of address, out of town for vacation, visiting out of town family, etc;
- Authorized representative did not pay timely on member's behalf;
- Lack of understanding of the ramifications of not paying plan premiums or Part D-IRMAA;
- Could not afford to pay premiums at the time of delinquency/disenrollment

For the purpose of determining "good cause" for members with authorized representatives, the criteria for both favorable and unfavorable determinations apply as though the authorized representative is the member. Thus, as noted above, failure to make timely payment by an authorized representative alone is not grounds for a favorable "good cause" determination and reinstatement.

An individual who is not assessed Part D-IRMAA remains disenrolled from the plan and does not have access to services until one of the following occurs:

- The plan receives full payment of all required amounts to satisfy a CMS-determined, favorable good cause case for failure to pay plan premiums,
- The plan is contacted by the CMS caseworker, or
- The reinstatement occurs and is reported on the TRR.

An individual who is assessed Part D-IRMAA remains disenrolled from the plan and does not have access to services until the reinstatement occurs and is reported on the TRR or the plan is contacted by the CMS caseworker after they have successfully updated the beneficiary's enrollment record in MARx. Once a reinstatement occurs, the individual's disenrollment will be cancelled and his/her coverage will be continuous, assuming the individual continues to be eligible for enrollment in that plan.

Process for "Good Cause" Determinations:
When a disenrolled member contacts the MA organization because s/he was disenrolled due to failure to pay plan or Part D-IRMAA premiums and states that s/he "has a good reason for not paying the premiums", the MA organization must advise the individual to contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) within 60 calendar days of the disenrollment effective date to make the "good cause" reinstatement request. The organization should also inform the individual that in order to be reinstated, s/he must meet specific "good cause" standards and must pay all overdue and current owed premiums (including both the plan

premium and Part D-IRMAA) within 3 months of the disenrollment date in order for reinstatement may occur.

Note: In cases where the involuntary disenrollment for failure to pay plan premiums is the result of plan error, plans should follow the reinstatement process outlined in Section 60.3.3. Plans should not refer these individuals to 1-800-MEDICARE to request reinstatement for "good cause."

Once a request is made with CMS via 1-800-MEDICARE, a CTM case will be generated for CMS caseworker action. The CMS caseworker will contact the individual and make a "good cause" determination. If the individual provides any documentation to the plan regarding the inability to make timely payment, the plan must provide that documentation to CMS (through the plan account manager) so that it may be considered in making the determination. CMS will notify the individual of the determination and, if favorable, explain the general process, including payment responsibilities and timing. Plans are required to provide more specific information to the individual, as outlined below. Notes of the "good cause" reinstatement request will be captured in the CTM for CMS and plan viewing. (Note: Requests for reinstatement are not considered complaints against the plan, therefore, these types of CTM cases are excluded from tracking for the purposes of plan ratings.)

If CMS makes a favorable determination, a notation will be made in the CTM "good cause" request case. CMS will communicate directly with plans regarding approved good cause determinations. If there are amounts owed to the plan for past due premiums, the plan must send notification to the beneficiary within 3 business days of being informed of the approved good cause determination. This notice will specify the amount owed, the date by which payment must be received for reinstatement (i.e., last day of the third month following effective date of disenrollment), and where to send payment (or other payment options such as credit card or direct withdrawal from a bank account)(See Exhibit 22a). Even if an individual has received a favorable good cause determination, the actual reinstatement will not occur until all required payments are made, provided they are received within three months of the disenrollment effective date. Within ten (10) calendar days of receipt of TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 25a).

In cases where an individual pays all premium amounts but does not receive a favorable "good cause" determination or receives a favorable good cause determination but does not pay the plan premium and/or the Part D-IRMAA owed within three months of the disenrollment effective date, s/he may not be reinstated. In both of these cases, the plan may re-enroll the individual for a prospective enrollment effective date at the beneficiary's request, if s/he has a valid election period (i.e., AEP, SEP, etc.), following enrollment procedures outlined in Sections 30 and 40.

Example A: Mr. Smith is disenrolled for failure to pay plan premiums on April 1. Mr. Smith contacts Medicare and makes his request on April 15 and receives a favorable good cause determination on April 23. Mr. Smith is not assessed a Part D-IRMAA and only owes plan premiums. The plan notifies Mr. Smith of the amount he owes by June 30 in order to be reinstated into the plan. Mr. Smith pays the amount due on June 15. Mr. Smith is reinstated into the plan. (Note: If Mr. Smith did not pay his owed amount by June 30, he would not be reinstated.)

Example B: Mr. Smith is disenrolled for failure to pay plan premiums on December 1. Mr. Smith contacts Medicare and makes his request on December 20 and receives a favorable good cause

determination on January 4. Mr. Smith is also delinquent on his Part D-IRMAA. CMS notifies Mr. Smith of the amount he owes by February 28 for Part D-IRMAA. The plan notifies Mr. Smith of the amount he owes by February 28 in order to be reinstated into the plan. Mr. Smith pays his Part D-IRMAA owed amount on February 7. Mr. Smith pays his plan premium owed amount on February 25. Mr. Smith is reinstated into the plan. (Note: If Mr. Smith did not pay either of his owed amounts by February 28, he would not be reinstated.)

Example C: Mr. Smith is disenrolled for failure to pay plan premiums on July 1. Mr. Smith mails in his past due amounts to the plan on July 30. He contacts Medicare and makes his request on August 10, and does not receive a favorable good cause determination. Mr. Smith may not be reinstated.

Example D: Mr. Smith is disenrolled for failure to pay plan premiums on November 1. Mr. Smith mails in his owed amounts to the plan on December 15, but does not request reinstatement with CMS. Thus, Mr. Smith does not have a favorable good cause determination, and he may not be reinstated.

Example E: Mr. Smith is disenrolled for failure to pay Part D-IRMAA on August 1. He contacts Medicare and makes his request on September 29 and receives a favorable good cause determination on October 5. Mr. Smith is also delinquent on his plan premiums. CMS notifies Mr. Smith of the amount he owes by October 31 for Part D-IRMAA. The plan also notifies Mr. Smith of the amount he owes by October 31 for plan premiums. Mr. Smith pays his Part D-IRMAA owed amount on October 25. Mr. Smith pays his plan premium owed amount on November 5. Mr. Smith may not be reinstated. (Note: If Mr. Smith had paid both his owed Part D-IRMAA and plan premiums by October 31, he would have been reinstated.)

The above examples apply for disenrollments for either failure to pay plan premiums or failure to pay Part D-IRMAA.

60.4 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the MA organization or CMS is unable to process the enrollment for the required effective date (as outlined in §30.5), CMS (or its designee) will process a retroactive enrollment.

In addition, auto-enrollment for full-benefit dual eligible as described in §40.1.5 may be retroactive to ensure no coverage gap between the end of Medicaid coverage for Part D drugs and the beginning of Medicare drug coverage.

In other limited cases, CMS may determine that an individual is eligible for an SEP due to an extraordinary circumstance beyond his/her control (e.g. a fraudulent enrollment request or misleading marketing practices) and may also permit a retroactive enrollment in an MA plan as necessary to prevent a gap in coverage or liability for the late enrollment penalty.

Unlike a reinstatement, which is a correction of records to “erase” an action, a retroactive enrollment is viewed as an action to enroll a beneficiary into a plan for a new time period. Therefore, retroactive enrollments may NOT be made back to a date when an MA plan was closed for enrollment.

NOTE: Keep in mind that unless an approved capacity limit applies, all MA plans are open for ICEP, IEP/D, AEP, and SEP enrollment requests; therefore, all MA plans are open for retroactive enrollments for these types of enrollment requests.

Occasionally, obtaining the information necessary to complete an enrollment request within the allowable timeframes will extend beyond the CMS systems cut-off date for transaction submission, thus making the effective date of enrollment "retroactive" to the current payment month. MA organizations must use the Code 61 enrollment transaction to submit the enrollment transaction directly to CMS within the Current Calendar Month transaction processing timeframe.

When a valid request for enrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, MA organizations are required to submit the appropriate documentation to CMS (or its designee) for manual review and potential action. The request for a retroactive enrollment should be made within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. When an individual has fulfilled all enrollment requirements, but the organization or CMS has been unable to process the enrollment in a timely manner, the following documentation must be submitted to CMS (or its designee):

- A copy of signed completed enrollment form (the form must have been signed by the beneficiary (or authorized representative) and received by the organization prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage);

Or

- A copy of the enrollment request record (the enrollment request record must show that the enrollment request was made and received by the organization prior to the requested effective date of coverage).

The retroactive enrollment request may be denied if CMS determines that the MA organization did not notify the member that he/she must use MA plan services during the period covered by the retroactive enrollment request.

If the request for retroactive enrollment action is due to plan error, the organization must provide a clear and detailed explanation of the plan error including why the retroactive action is necessary to correct the error. The explanation must include clear information regarding what the organization has communicated to the affected beneficiary throughout the period in question. The organization must also include any relevant information or documentation supporting the requested correction. Such information could include a copy of the enrollment request form (or clear evidence of the use of another enrollment mechanism) and evidence of notices sent to the beneficiary related to or caused by the error.

Special note regarding Regional Office Casework actions

When an MA organization is directed by CMS, such as via an RO caseworker, to submit a retroactive enrollment or disenrollment request to resolve a complaint, the organization must provide the following 2 (two) items as documentation to CMS (or its designee):

- A screen print from the Complaint Tracking Module (CTM) or other documentation showing the CMS RO decision and direction to submit the request to the CMS Retroactive Processing Contractor, and;
- A copy of the enrollment or disenrollment request, if one is available. Occasionally, due to the nature of casework, this item may not be available. When that occurs, the organization should submit a brief statement of explanation for the missing documentation.

60.5 - Retroactive Disenrollments

If an enrollment was never legally valid (§40.6) or if a valid request for disenrollment was properly made, but not processed or acted upon (as outlined in the following paragraph), which includes not only system error, but plan error (see §10 for a definition of "system error" and "plan error"), CMS (or its designee) may grant a retroactive disenrollment. CMS (or its designee) may also process a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the plan service area (as outlined in §50.2.1.2), a contract violation (as outlined in 42 CFR 422.62(b)(3)) or other limited exceptional conditions established by CMS (e.g. fraudulent enrollment or misleading marketing practices).

When a valid request for disenrollment has not been communicated to CMS successfully within the required timeframes in this guidance and the Current Calendar Month transaction submission timeframe, MA organizations are required to submit the appropriate documentation to CMS (or its designee) for manual review and potential action. Retroactive disenrollment requests can be submitted to CMS (or its designee) by the beneficiary or an MA organization. Requests from an MA organization must include a copy of the disenrollment request, as well as an explanation as to why the disenrollment was not processed correctly. MA organizations must submit retroactive disenrollment requests to CMS (or its designee) within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. If CMS approves a request for retroactive disenrollment, the MA organization must return any premium paid by the member for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

A retroactive request must be submitted by the MA organization (or by the member) to CMS (or its designee) in cases in which the MA organization has not properly processed a required involuntary disenrollment or acted upon the member's request for disenrollment as required in §50.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §30.6.

If the request for retroactive disenrollment action is due to the MA organization's confirmation of an incarcerated status with a retroactive start date (see § 50.2.1.3), the organization must provide written confirmation of the incarcerated status, including the start date. Such confirmation could include documentation of telephonic communications.

If the request for retroactive action is due to plan error, the organization must provide a clear and detailed explanation of the plan error including why the retroactive action is necessary to correct the error. The explanation must include clear information regarding what the organization has communicated to the affected beneficiary throughout the period in question, including evidence that the beneficiary was notified prospectively of the disenrollment. The organization must also include any relevant information supporting the requested correction. Such information could include a copy of the disenrollment request and evidence of notices sent to the beneficiary

related to or caused by the error in question and which demonstrate that the retroactive disenrollment is appropriate under the circumstances.

60.6 - Retroactive Transactions for Employer/Union Group Health Plan (EGHP) Members

In some cases an MA organization that has a contract with an EGHP arranges for the employer or union to process enrollment requests for Medicare-entitled group members who wish to enroll in an employer or union sponsored MA plan. However, there can be a delay between the time the member completes the enrollment request through the EGHP and when the enrollment request is received by the MA organization. Therefore, retroactive transactions for these routine delays may be necessary and are provided for under this section. Errors made by an EGHP, such as failing to forward a valid enrollment or disenrollment request within the timeframes described below, must be submitted to CMS (or its designee) for review. Repeated errors may indicate an ongoing problem and therefore will be forwarded to the MA organization's CMS Account Manager for compliance monitoring purposes. The MA organization's agreement with the EGHP must include the need to meet the requirements provided in this chapter that ensure the timely submission of enrollment and disenrollment requests to reduce the need for retroactivity and to help avoid such errors.

60.6.1 - EGHP Retroactive Enrollments

The effective date of EGHP enrollments cannot be earlier than the date the enrollment request was completed by the beneficiary. The effective date may be retroactive up to, but may not exceed, 90 days from the date the MA organization received the request (which was completed prior to the effective date) from the employer or union group.

EXAMPLE

In March 2007, the CMS system processing date was March 13, 2007. Enrollment requests processed by CMS for the March 13, 2007, due date were for the prospective April 1, 2007, payment. For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30, 60 and 90 days of retroactive payment adjustment, respectively. Therefore, if a completed EGHP enrollment request were to be received by the MA organization on March 5, 2007, the retroactive effective date could be January 1, February 1, or March 1, as long as the enrollment request was completed prior to the effective date.

> **NOTE:** Keep in mind that unless a capacity limit applies, all MA plans are open for ICEP, AEP, and SEP enrollment requests. Therefore, all MA plans are open for retroactive enrollments for these types of enrollment requests.

No retroactive enrollments may be made unless the individual certifies that the MA organization (or EGHP) provided him/her with the explanation of enrollee rights (including the lock-in requirement) at the time of enrollment. The MA organization should submit such enrollments using the appropriate transaction code. Refer to the Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) for more information. The ability to submit limited EGHP retroactive enrollment transactions is to be used only for the purpose of submitting a retroactive enrollment into an EGHP made necessary due to the employer's delay in forwarding the completed enrollment request to the MA organization.

60.6.2 - EGHP Retroactive Disenrollments

The MA organization must submit a retroactive disenrollment request to CMS (or its designee) if an EGHP does not provide the MA organization with timely notification of a member's requested disenrollment. Up to 90 day's retroactive **payment** adjustment is possible in such a case to conform to the adjustments in payment described under 42 CFR 422.308(f)(2). The EGHP notification is considered untimely if it does not result in a disenrollment effective date as outlined in §30.6.

The MA organization must submit a disenrollment notice (i.e., documentation) to CMS (or its designee) demonstrating that the member acted to disenroll in a timely fashion (i.e., prospectively), but that the EGHP was late in providing the information to the MA organization. Such documentation may include an enrollment form for a new MA plan signed by the member and given to the EGHP during an open enrollment season. The documentation may not include a copy of a Medicare supplemental plan or Medigap plan enrollment form unless the member indicated on that form that he/she has canceled any other insurance. Such documentation should be sent to CMS (or its designee) as soon as possible.

60.7 – User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries

Upon receipt of a CMS transaction reply, MA organizations must update their records to accurately reflect each individual's enrollment status. Organizations are also required to provide certain notices and information to beneficiaries when enrollment status is confirmed or changes. In the case of UI-TRC replies, the standard operating procedures for providing these notices and/or information may not fit some of the unique situations many UI enrollment changes address.

The table below provides guidelines for communicating with beneficiaries when enrollment changes are reported to MA organizations using the "700 series" TRCs that result from UI enrollment changes. In all cases, organizations will need to review the situations carefully to determine the necessity and appropriateness of sending notices. Some UI enrollment change processes will result in multiple 700-series TRCs being reported. Organizations must determine the final disposition of the beneficiary to ensure the correct message is provided in any notice sent. In complex situations, CMS encourages organizations to communicate directly (such as by telephone) with the beneficiary, in addition to any required notice or materials. When it is necessary to send a notice, organizations must issue the notice within ten calendar days of receipt of the TRR.

TRC	Beneficiary Communication Action
701 – New UI Enrollment	Organizations may use existing confirmation notices as provided in CMS enrollment guidance. If such notice has already been provided with the same information, it is not necessary to provide it a second time.
702 – New UI Fill-in Enrollment	Organizations must use Exhibit 30, "Enrollment Status Update." Include the date range covered by the new fill-in period.
703 – UI Enrollment Cancel	If a cancellation notice applicable to this time period has already been provided, it is not necessary to provide it a second time. If notice has not been provided, organizations may use the existing cancellation of enrollment notice as provided in CMS enrollment

	guidance. If the specific situation warrants, organizations may use Exhibit 30 instead, providing information that clearly indicates that the enrollment period in question has been cancelled. Include information about the refunding of plan premiums, if applicable.
704 – UI Enrollment Cancel - PBP Change	If the UI action is a correction to a plan submission error, the organization may have already provided the correct plan (PBP) information; if that's the case, it is not necessary to send it a second time. If the beneficiary has not received information about the specific plan (PBP), the organization must send the materials required in CMS enrollment guidance that would be provided for any new enrollment. Organizations must also send Exhibit 30 describing the plan change, including the effective date. The impact of the change on plan premiums, cost sharing, and provider networks must be communicated clearly. It is not necessary to confirm with a notice the associated "enrollment canceled" TRC that will accompany the enrollment into the new plan (PBP).
705 – New UI Enrollment - PBP Change	Follow the guidance provided above for TRC 704.
706 – UI Enrollment Cancel - Segment change	Plan (PBP) segment changes apply only to MA plans. Provide updated materials reflecting the new elements of the changed segment, such as premium and cost sharing increases or decreases.
707- UI New enrollment - Segment Change	Follow the guidance above for TRC 706.
708 – UI End Date Assigned	This UI action has the same effect as a plan submitted disenrollment (code 51) transaction. Generally, organizations should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated changes are retroactive, organizations may have already provided notice (with correct effective dates) and if so, need not provide it a second time. Additional clarification may be appropriate depending on the specifics of the case.
709 – UI Earlier Start Date	An existing enrollment period in the plan has changed to start earlier than previously recorded. If the organization has already provided notice reflecting this effective date of enrollment, it is not necessary to provide it a second time. When the individual has not already received notice reflecting this effective date, organizations may use existing confirmation of enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, organizations may use Exhibit 30, including in it the new effective date and information about additional premium liability (ensure flexibility in allowing payment arrangements where necessary). Organizations must also ensure individuals are fully aware of how to access coverage of services for the new time period, including their right to appeal.
710 – UI Later Start Date	An existing enrollment period start date has been changed to start on a later date. Organizations must use Exhibit 30. Organizations must explain the change in the effective date of coverage, and provide information on the refunding of any premiums paid. Organizations must also explain the impact on any paid claims from the time period affected.

711 – UI Earlier End Date	An enrollment period end date has been changed to occur earlier. Organizations must use Exhibit 30. Organizations must explain the change in the effective date of the end of coverage, and provide information on the refunding of any premiums paid. Organizations must also explain the impact on any paid claims from the time period affected.
712 – UI Later End Date	An enrollment period end date has been changed to occur later. Organizations must use Exhibit 30. Organizations must explain the change in the effective date of the end of coverage, and provide information on any premiums the individual may owe for the extended period. Organizations must also ensure beneficiaries are fully aware of how to access coverage of services for the new time period.
713 – UI Removed End Date	An enrollment period that previously had an end date is now open (and ongoing). Organizations must use Exhibit 25a to explain the change and that enrollment in the plan is now continuous. Organizations must provide information on any plan premiums and ensure beneficiaries are fully aware of how to access coverage of services for the new time period and going forward.

60.8 - Election of Continuation of Enrollment Option for MA Local Plans

When a member permanently moves into the MA organization's continuation area, the member must make a positive choice to continue enrollment in the MA local plan. The member does not have to complete and sign a new enrollment form in order for the continuation to occur but must make this choice in a manner described in the MA organization's policy and procedure documents.

The MA organization must verify that the member has established permanent residence in the continuation area. Proof of permanent residence is normally established by the address of the residence, but the MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual.

The effective date of a continuation of enrollment change generally is the first day of the month after the individual moves into the continuation area.

60.9 - Storage of Enrollment and Disenrollment Records

As stated at 42 CFR 422.60(c)(2), MA organizations are required to file and retain enrollment request forms. MA organizations must retain and have available for evaluation enrollment and disenrollment records for the current contract period and ten (10) prior years (42 CFR 422.504(e)(4)).

It is appropriate to allow for storage on microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms and other enrollment requests may also be allowed, such as optically scanned forms stored on disk.

Records of MA enrollment and disenrollment requests made by any other enrollment request mechanism (as described in §40.1) must also be retained as above.

Appendices

Summary of
Medicare Advantage Notice and
Data Element Requirements

Appendix 1: Summary of Notice Requirements

Referenced in sections: 10, 30, 40, 50, and 60

This Exhibit is intended to be a summary of notice requirements. For exact detail on requirements and time frames, refer to the appropriate sections within this guidance.

Notice	Section	Required?	Timeframe
Model Enrollment Form (Exh. 1)	10, 40.1.1, 40.2, 40.4.1	Yes[3]	NA
Information to include on or with Enrollment Mechanism -- Attestation of Eligibility for an Enrollment Period (Exh. 1a)	30.4	No	NA
MA MSA Enrollment Form (Exh 1b)	40.1.1	Yes[4]	NA
MA PFFS Enrollment Form (Exh 1c)	40.1.1	Yes[5]	NA
EGHP Enrollment Form (Exh. 2)	10, 40.1.1, 40.2, 40.4.1	No	NA
Short Enrollment Forms (Exh. 3 and 3a)	10, 40.1.1, 40.2, 40.4.1	No	NA
Acknowledgment of Receipt of Completed Enrollment Request (Exh. 4 and 4a)	40.4.1, 60.4	Yes[6]	10 calendar days of receipt of completed enrollment request
Combination Acknowledgement and Confirmation Notice (Exh. 4b)	40.4	Yes[7]	7 calendar days of availability of the TRR
Acknowledge Receipt of Completed PFFS Enrollment Request (Exh.4c)	40.4.1, 60.4	Yes[8]	10 calendar days of receipt of completed enrollment request
Notice to Acknowledge Receipt of Completed PFFS Enrollment Request and to Confirm Enrollment in a PFFS Plan (Exh. 4d)	40.4.1, 60.4	Yes	7 calendar days of availability of the TRR

[3] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[4] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[5] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[6] Required unless combined acknowledgment/confirmation notice is issued.
[7] Required if the MAO has chosen to provide a single notice in response to the TRR, as described in §40.4.1.
[8] Required unless combined acknowledgment/confirmation notice is issued.

Notice	Section	Required?	Timeframe
Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment in Another Plan Within the Same Parent Organization (Exh. 4e)	40.4	Yes	7 calendar days of the availability of the TRR
Request for Information (Exh. 5)	30, 40.2.2	No	10 calendar days of receipt of enrollment request
Confirmation of Enrollment (Exh. 6,6a, 6d)	40.4.2, 40.6	Yes[9]	10 calendar days of availability of TRR
Notice to Individuals Identified on CMS Records As Members of Employer or Union Group Receiving Retiree Drug Subsidy (Exh. 6b)	40.2.5	Yes	10 calendar days of availability of TRR
Confirm PFFS Enrollment (Exh. 6c)	40.4.2	Yes[10]	10 calendar days of availability of TRR
MAO Denial of Enrollment (Exh. 7)	40.2.3	Yes	10 calendar days of receipt of enrollment request OR expiration of time frame for requested additional information
CMS Rejection of Enrollment (Exh. 8)	40.4.2	Yes	10 calendar days of availability of TRR (exception described in §40.4.2)
Sending Out Disenrollment Form/Disenrollment Form (Exh. 9, 9a, & 10)	50.1	No	NA
Information to include on or with Disenrollment Form -- Attestation of Eligibility for an Election Period (Exh. 10a)	30.4	No	NA
Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11)	50.1, 50.4.1	Yes	10 calendar days of receipt of request to disenroll
Request Information (Disenrollment) (Exh. 11a)	30, 50.4.2	Yes	10 calendar days of receipt of disenrollment request
Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)	50.1	No	NA

[9] Required unless combined acknowledgment/confirmation notice is issued.
[10] Required unless combined acknowledgment/confirmation notice is issued.

Notice	Section	Required?	Timeframe
Confirmation of Voluntary Disenrollment Identified Through TRR (Exh. 12)	50.1, 50.4.1. 60.3.2	Yes	10 calendar days of availability of TRR
Denial of Disenrollment (Exh. 12a)	50.1.4	Yes	10 calendar days of receipt of disenrollment request
Rejection of Disenrollment (Exh. 12b)	50.1	Yes	10 calendar days of availability of TRR
Final Confirmation of Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	No	NA
Disenrollment Due to Death (Exh. 13)	50.2.3, 50.4.2, 60.3.1	No	NA
Disenrollment Due to Loss of Part A and/or Part B Coverage (Exh. 14)	50.2.2, 50.4.2, 60.3.1	No	NA
Notices on Terminations/Non-renewals	50.2.4	Yes	Follow requirements in 42 CFR 422.506 - 422.512
Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	50.3.2	Yes	NA
Disenrollment for Disruptive Behavior (no exhibit)	50.3.2	Yes	Before the disenrollment transaction is submitted to CMS
Disenrollment for Fraud and Abuse (no exhibit)	50.3.3	Yes	Before the disenrollment transaction is submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	60.3, 60.3.1	Yes	10 calendar days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Part A/B Termination (Exh. 16)	60.3, 60.3.1	Yes	10 calendar days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error (Exh 17)	60.3, 60.3.1	Yes	10 calendar days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	60.3.2	Yes	10 calendar days after information was due to MA organization
Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)	50.3.1	Yes	Within 15 calendar days of the premium due date

Notice	Section	Required?	Timeframe
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	50.3.1	Yes	3 business days following the last day of the grace period
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	50.3.1	No	NA
Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount (Exh. 21a)	50.2.6	Yes	10 calendar days of notification on the TRR
Failure to Pay Plan Premiums - Notice of Reduction in Coverage (Exh. 22)	50.3.1	Yes	10 calendar days of the expiration of the grace period
Notice of Favorable "Good Cause" Determination – Notification of Premium Amount Due for Reinstatement (Exh. 22a)	60.3.3	Yes	3 business days following the notification by CMS of favorable "good cause" determination
Public Notices For Closing Enrollment due to Capacity Limit (Exh. 23)	40.5	Yes	15 days if related to CMS approved capacity limit
Notice that Enrollment request Placed on Waiting List (no exhibit)	40.5.1, 40.5.2	Yes	10 calendar days of receiving enrollment request or of approval from CMS to limit enrollment
Re-affirming Intent to Not Enroll (no exhibit)	40.5.1, 40.5.2	No	10 days of contacting member
Intent to Not Process Enrollment (no exhibit)	40.5.1, 40.5.2	Yes	10 calendar days of learning beneficiary no longer wants to enroll
Medigap Rights per Special Election Period (Exh. 24)	50.2, 50.1	No	Upon request.
Request to cancel enrollment (Exh. 25)	60.2.1	Yes	10 calendar days of request
Confirmation of Reinstatement Per Notification From CMS (Exh. 25a)	60.2.1, 60.2.2, 60.3, 60.3.1, 60.3.2	Yes	10 calendar days of TRR confirming reinstatement
Request to cancel disenrollment (Exh. 26)	60.2.2	Yes	10 calendar days of request
Inform Member of Auto-Enrollment (Exh. 27)	40.1.5	Yes	10 calendar days of identifying individual as needing auto-enrollment

Notice	Section	Required?	Timeframe
Inform FBDE Member of Auto-Enrollment in PDP (Exh. 27a)	40.1.5	Yes	10 calendar days of identifying individual as needing auto-enrollment
Inform Member of Facilitated Enrollment (Exh. 28)	40.1.5	Yes	10 calendar days of identifying individual as needing facilitated enrollment
Inform Member of Facilitated Enrollment into PDP (Exh. 28a)	40.1.5	Yes	10 calendar days of identifying individual as needing facilitated enrollment
Request to Decline Part D (Exh. 29)	40.1.5	Yes	10 calendar days of request
Enrollment Status Update (Exh. 30)	60.7	As necessary	10 calendar days of availability of TRR
Model Employer/Union Group Enrollment Mechanism Notice (Exh 31)	40.1.6	Yes	21 calendar days prior to effective date of enrollment
Loss of SNP Status (Exh 32)	50.2.5	Yes	10 calendar days of loss of special needs status
Loss of SNP Status - Notification of Involuntary Disenrollment (Exh 33)	50.2.5	Yes	3 business days of expiration of period of deemed continued eligibility
Research Potential Out of Area Status (Exh 34)	50.2.1.3	Yes	10 calendar days of receiving notice of change of address or indication of possible out-of-area residency
Disenrollment Due to Out of Area Status (No Response to Request for Address Verification) (Exh 35)	50.2.1.3	Yes	Within first 10 calendar days of the sixth month.
Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member) (Exh 36)	50.2.1.3	Yes	10 calendar days of receiving confirmation of out of area status

Appendix 2: Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests

Referenced in section(s): 20, 20.4, 40.2, 40.4.1

All data elements with a "Yes" in the "Beneficiary response required on request" column are necessary in order for the enrollment to be considered complete.

Data Element		CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
1	MA Plan name[11]	Yes	Yes	1, 1b, 1c, 2, 3, 3a
2	Beneficiary name	Yes	Yes	1, 1b, 1c, 2, 3, 3a
3	Beneficiary Date of Birth	Yes	Yes	1, 1b, 1c, 2
4	Beneficiary Sex	Yes	Yes	1, 1b, 1c, 2
5	Beneficiary Telephone Number	Yes	No	1, 1b, 1c, 2, 3
6	Permanent Residence Address (with the exception of "County" – see below)	Yes	Yes	1, 1b, 1c, 2, 3
7	County (Optional Field)	No	No	1, 1b, 1c, 2, 3
8	Mailing Address	Yes	No	1, 1b, 1c, 2, 3
9	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No	No	1, 1b, 1c, 2
10	E-mail Address (Optional Field)	No	No	1, 1b, 1c, 2, 3
11	Beneficiary Medicare number	Yes	Yes	1, 1b, 1c, 2, 3
12	Additional Medicare information contained on sample Medicare card, or copy of card	No	No	1, 1b, 1c, 2
13	Plan Premium Payment Option	Yes[12]	No[13]	1, 1b, 1c, 3, 3a
14	Response to ESRD Question	Yes	Yes	1, 1b, 1c, 2
15	Response to long term care question	No	No	1, 1b, 1c, 2
16	Response to other insurance COB information	Yes	No[14]	1, 1b, 1c, 2
17	Language preference and alternative formats	Yes	No	1, 1b, 1c, 2, 3

[11] If enrollment mechanism will be used for multiple plans, all plan names must be listed in a way that permits the applicant to clearly indicate his/her plan choice.
[12] Zero premium MA-only plans omit this question
[13] Response defaults to direct bill if applicant fails to provide information
[14] Refer to CMS COB guidance for additional information

Data Element		CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
18	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	No	2
19	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No	No	2
20	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	No	2
21	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No	No	1, 1b, 1c, 2, 3
22	Beneficiary signature and/or Authorized Representative Signature	Yes	Yes[15]	1, 1b, 1c, 2, 3,3a
23	Date of signature	Yes	No[16]	1, 1b, 1c, 2, 3, 3a
24	Authorized representative contact information	Yes	Yes	1, 1b, 1c, 2,3, 3a
25	Employer or Union Name and Group Number	Yes	Yes	2
26	Question of which MA plan the beneficiary is currently a member of and to which MA plan the beneficiary is changing	Yes	Yes	3
27	For Special Needs Plans, description of SNP eligibility criteria	Yes	Yes	N/A
28	For MSA plans, all additional elements including proof that MSA bank account has been established	Yes	Yes	N/A

[15] For Employer/Union Group MA enrollment elections as described in §40.1.6, and some other CMS approved enrollment elections, a signature is not required. For paper enrollment forms submitted without a signature, organization may verify with the applicant by telephone and document the contact instead of returning form.

[16] As explained in §40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the MA organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element. For employer group MA elections as described in §40.4.1, the "signature date" is the date the employer's process was completed as recorded.

Data Element		CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
29	Information provided under “please read and sign below” All elements provided in model language must be included on enrollment request mechanisms. Option -- can be provided as narrative or listed as statements of understanding	Yes	Yes	1, 1b, 1c, 2
30	Release of Information All elements provided in model language must be included on enrollment request mechanisms.	Yes	Yes	1, 1b, 1c, 2
31	Option to request materials in language other than English or in other formats	Yes	No	1, 1b, 1c, 2, 3, 3a

Appendix 3: Setting the Application Date on CMS Enrollment Transactions

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the beneficiary's choice of plan is honored. The application date is always a date prior to the effective date of enrollment.

Enrollment request Mechanism	**Application Date**	**Special Notes**
Paper Enrollment Forms §40.1.1	The date the paper request is initially received	Paper requests submitted to or collected by sales agents or brokers are received by the MA organization on the date the agent or broker receives the form
Enrollment forms received by Fax §40.1.1	The date the fax is received on the MA organization's Fax machine	
Medicare.gov Online Enrollment Center (OEC) §40.1.2	The date "stamped" by CMS on the request	
MA organization *electronic*~~*Web site online*~~ enrollment *process*~~page~~ §40.1.2	The date the *enrollee completes the* request ~~is completed~~ via the *electronic enrollment*~~*organization's website*~~ process	*The electronic enrollment process must capture the application date as the day that the individual completes the request as part of the process itself.*
Approved Telephonic Enrollment §40.1.3	The date of the call	
Seamless Conversion Option for Newly Eligible MA Members §40.1.4	First day of individual's Initial Coverage Election Period (ICEP)	Effective date must always be the date of the individual's first entitlement to **both** Medicare Part A and Part B
Other Special Processes for Application Dates		
All enrollment requests into employer or union sponsored plans using the SEP EGHP, regardless of mechanism used	1st day of the month prior to the effective date of enrollment	This applies to all mechanisms including §§40.1.3 and 40.1.6
Auto and Facilitated Enrollment §40.1.5	The 1st of the month prior to the effective date of the auto/facilitated enrollment	
SPAP enrollment requests as permitted in §40.1.8 made during the AEP	October 15th	The effective date of enrollment is the following January 1st

EXHIBITS

Model Medicare Advantage Enrollment Forms & Notices

This section contains model exhibits for plan issued notices to beneficiaries regarding enrollment matters. MA organizations may make the following modifications to CMS model materials and still submit the material to CMS under the ten (10) day review period: populating variable fields, correcting grammatical errors, changing the font (within standards described in the CMS marketing guidelines), adding the plan name/logo, and adding the CMS marketing material identification number.

For more information on CMS marketing and mailing requirements as well as the instructions for submitting model documents for review, see sections 90.3.6 and 90.7.3 of the CMS marketing guidelines.

Exhibit 1: Model MA Individual Enrollment Request Form ("Election" may also be used)

Referenced in section(s): 10, 40.1, 40.2, 50.1

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan>, Please Provide the Following Information:			
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number: ( )]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field*: **Emergency contact:** _____ **Phone Number**:_____ **Relationship to You:** _____]			
[*Optional field:* **E-mail Address:** _____]			

Please Provide Your Medicare Insurance Information	
Please take out your Medicare card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

[***Zero premium MA-only plans may omit this section***:

Paying Your Plan Premium

[*Zero premium MA-PD plans insert the following***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail,** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium** [*MA-PD plans with premiums insert:* **(including any late enrollment penalty that you currently have or may owe)] by mail** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.]**

[*MA-PD plans with premiums insert:* **If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

☐ Get a bill <option: "coupon", "payment" book, etc>
<*option to include other billing intervals e.g. bi-monthly, quarterly*>

[*Optional - Include other payment methods, such as EFT & credit card, as follows:*
☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____
Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _
Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card: _____
Name of Account holder as it appears on card: _____
Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Expiration Date: _ _/_ _ _ _ (MM/YYYY)]

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

[*MA-PD plans insert:*

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <MA plan>? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ID # for this coverage: Group # for this coverage

_____ _____
_____]

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes," please provide the following information:

Name of Institution: _____

Address & Phone Number of Institution (number and street):_____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

[Special Needs Plans insert question(s) regarding the required special needs criteria (i.e. "Do you live in a long term care facility" or "Do you have diabetes?"]

[*Optional field:* **Please choose the name of a Primary Care Physician (PCP), clinic or health center:**]

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

____ <include list of available languages>

____ <include list of other formats (like Braille, audio tape, or large print) >

Please contact <plan name> at <phone number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number.>

[***Following box required only for MA-PD plans*:**

Please Read This Important Information

If you currently have health coverage from an employer or union, joining <MA-PD Name> could affect your employer or union health benefits. You could lose your employer or union health coverage if you join <MA-PD name>. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.]

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

<Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [***MA-only plans insert*:** I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for

limited coverage near the U.S. border.

I understand that beginning on the date <plan name> coverage begins, I must get all of my health care from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. [*PPOs use the following in place of the first sentence:* "I understand that beginning on the date <plan name> coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, <plan> provides refunds for all covered benefits, even if I get services out of network."] Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <PLAN NAME> WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that <plan name> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [***MA-PD plans insert:*** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]

Exhibit 1a: Information to include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period

Referenced in section: 30.4

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date)_____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.

- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact <plan name> at <phone number> (TTY users should call <TTY number>) to see if you are eligible to enroll. We are open <insert days and hours of operation>.

Exhibit 1b: Model MA MSA Plan Enrollment Request Form ("Election" may also be used)

Referenced in §40.1.1

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan name>, Please Provide the Following Information:			
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number: ( )]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field:* **Emergency contact:** _____ **Phone Number**: _____**Relationship to You:** _____]			
[*Optional field:* **E-mail Address:** _____]			

Please Provide Your Medicare Insurance Information	
Please take out your Medicare card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

Please read and answer these important questions
1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No Generally, if you answered "yes" you aren't eligible to enroll in <MSA plan name>. If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
2. To enroll in <MSA plan name>, you may not have other health coverage as described below. Please answer each of the following questions: **A.** Are you enrolled in your State Medicaid program? ☐ Yes ☐ No **B.** Are you receiving Medicare Hospice benefits? ☐ Yes ☐ No **C.** Some individuals may have other health coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or other health benefits that cover all or part of the annual Medicare MSA deductible. If you have any other such coverage, you aren't eligible to enroll in <MSA plan name> Will you have other health coverage in addition to <MSA plan name>? ☐ Yes ☐ No If "yes", please list your other coverage and your identification (ID) number(s) for this coverage so we can decide if you are eligible to enroll in <MSA plan name>: Name of other coverage: ID # for this coverage: Group # for this coverage _____ _____ _____
3. Will you reside in the United States for at least 183 days during each year you are enrolled in <MSA plan>? ☐ Yes ☐ No
4. Do you or your spouse work? ☐ Yes ☐ No
Please check one of the boxes below if you would prefer that we send you information in a language other than English or another format: ____ <include list of available languages> ____ <include list of other formats (like Braille, audio tape, or large print> Please contact <plan name> at <phone number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.

Please Read and Sign Below:
By completing this enrollment application, I agree to the following: <MSA Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time

and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any health coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan ("disenroll") during the Annual Enrollment Period that is October 15th through December 7th of every year (effective the following January 1st) or under certain limited special circumstances, by sending a request in writing to <MSA plan name>. If I choose a Medicare MSA plan and haven't before joined an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan isn't complete until the bank account is established. I understand that I am enrolling in a plan that doesn't pay for Medicare covered services until a high deductible is met, but <plan name> allows me to use funds in my MSA account to pay for health services. Withdrawals made from the MSA bank account aren't taxed when used for IRS-qualified medical expenses. I would owe income tax and up to a 50% penalty for withdrawals used for non-medical expenses. After the deductible is met the plan pays 100% of Medicare-covered services.

[*MSA Demonstration Plans insert*: If I am enrolling in a MSA demonstration plan, I may be responsible for cost sharing for certain preventive services, as described by the plan, before the deductible is met. After the deductible is met, I may be responsible for cost-sharing until my expenses for covered services reach the out-of-pocket maximum, after which the MSA demonstration plan pays 100% of Medicare covered services.]

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact the <plan name> at < contact number>.

<MSA plan name> serves a specific service area. If I move out of the area that <MSA Plan Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <MSA plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <MSA plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

I understand that if I disenroll before the end of the plan year (December 31st), <plan name> may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months left in the year after the disenrollment date. I understand that, if I die, my estate will be responsible for any money owed to Medicare. My estate keeps any amount over what is owed to Medicare.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <MSA plan name> will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.	
Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information: Name: _____ Address: _____ Phone Number: (___) ____- _____ Relationship to Enrollee _____ Keeping records -- As an authorized representative, it is important that you keep records of when funds in the MSA account are used, as well as how the funds are used.	

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]

Exhibit 1c: Model PFFS Individual Enrollment Request Form ("Election" may also be used)

Referenced in section(s): 10, 20.4, 40.1, 40.2

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan>, Please Provide the Following Information:			
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number:]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field*: **Emergency contact: _____** **Phone Number**:_____ **Relationship to You: _____**]			
[*Optional field:* **E-mail Address: _____**]			

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan such as <plan name>.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

[***Zero premium MA-only plans omit this section***:

Paying Your Plan Premium

[*Zero premium MA-PD plans insert***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board . DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium [***MA-PD plans with premium insert:* **(including any late enrollment penalty you have or may owe)] by mail** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.**

[*MA-PD plans with premiums insert:* **If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board. DO NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

☐ Get a bill <option: "coupon", "payment" book, etc>
<*option to include other billing intervals e.g. bi-monthly, quarterly*>

[*Optional - Include other payment methods, such as EFT & credit card as follows:*

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____
Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _
Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card: _____
Name of Account holder as it appears on card: _____
Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Expiration Date: _ _/_ _ _ _ (MM/YYYY)]

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)]

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

[*PFFS-PD plans insert:*
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <PFFS plan>? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: ID # for this coverage: Group # for this coverage

_____ _____ _____]

3. Do you or your spouse work? ☐ Yes ☐ No

[*Optional field:* **Please tell us the name of your Primary Care Physician (PCP):**
Doctor's Name: _____ Phone Number: _____]

[*Optional field:* **Please tell us the name of your preferred hospital, clinic or health center:**
Name: _____ City: _____ State: _____]

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

____ <include list of available languages>

____ <include list of other formats (like Braille, audio tape, or large print)>

Please contact <plan name> at <phone number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.

Please Read This Important Information

[*All PFFS plans insert:* <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <plan name> before each visit Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*All PFFS plans insert, except for cases in which beneficiary is switching from one PFFS plan to another PFFS plan offered by the same MAO*: Once <plan name> has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in <plan name>. If <plan name> isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.]

[*PFFS-PD plans insert:* If you currently have health coverage from an employer or union, joining <PFFS-PD Name> could affect your employer or union health benefits. If you have health coverage from an employer or union, joining <PFFS-PD Name> may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.]

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

<Plan Name> is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan [*PFFS w/PD insert* "or Medicare prescription drug plan."]. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [*PFFS w/o PD only plans insert:* "I understand that since this plan does not offer Medicare prescription drug coverage, I may get coverage from another Medicare prescription drug plan. If I don't have Medicare prescription drug

coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future."] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.

As a Medicare Private Fee-For-Service plan, <plan name> works differently than a Medicare supplement plan as well as other Medicare Advantage plans. <Plan name> pays instead of Medicare, and I will be responsible for the amounts that <plan name> doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in <plan name>.

Before seeing a provider, I should verify that the provider will accept <plan name>. I understand that my health care providers have the right to choose whether to accept <plan name>'s payment terms and conditions every time I see them. I understand that if my provider doesn't accept <plan name>, I will need to find another provider that will.

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify <plan name> so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I get it to know which rules I must follow in to get coverage with this Private Fee-For-Service plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [**PFFS-PD plans insert:** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	***Today's Date:***

If you are the authorized representative, you must sign above and provide the following information:

Name: _____
Address: _____
Phone Number: *(___)* ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]

Exhibit 2: Model Employer/Union Group Health Plan Enrollment Request Form ("Election" may also be used)

Referenced in section(s): 10, 40.1, 40.2, 50.1

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan name>, Please Provide the following Information:			
Employer or Union Name:		Group #:	
[*Required if form used for multiple plans:* **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month]			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Home Phone Number: ( )	[*Optional field*: Alternate Phone Number:]
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
[*Optional field:* **E-mail Address:** _____]			
Please Provide Your Medicare Insurance Information			
Please take out your Medicare card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card - OR - • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____		

Please read and answer these important questions
1. Are you the retiree? ☐ Yes ☐ No If yes, retirement date (month/date/year): _____ If no, name of retiree: _____
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No If yes, name of spouse: _____ Name(s) of dependent(s): _____
3. Do you or your spouse work? ☐ Yes ☐ No
4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to <plan name>? ☐ Yes ☐ No If "yes", please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: ID # for Coverage: _____ _____
6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No If "yes" please provide the following information: Name of Institution: _____ Address & Phone Number of Institution (number and street):_____
[*Optional field:* **Please Choose a Primary Care Physician (PCP), clinic or health center:**]
Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format: ____ <include list of available languages> ____ <include list of other formats (like Braille, audio tape, or large print)> Please contact <plan name> at <phone number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.

Please Read and Sign Below
By completing this enrollment application, I agree to the following: <Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare

health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [***MA-only plans insert*:** I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

<Plan Name> serves a specific service area. If I move out of the area that <Plan Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***MA PFFS do not include the following paragraph:*** I understand that beginning on the date <plan name> coverage begins, I must get all of my health care from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**]

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [***MA-PD plans insert:*** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information: Name: _____ Address: _____	

Phone Number: (___) ____- _____
Relationship to Enrollee _____

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____
[*optional space for other administrative information needed by plan*]

Exhibit 3: Model Short Enrollment Request Form ("Election" may also be used)

This form may be used in place of the model individual enrollment form when a member of a MA plan is enrolling into another MA plan offered by the same parent organization. This form is not applicable to MSA.

Referenced in section(s): 10, 20.4, 40, 40.1

Name of Plan You are Enrolling In: _____			
Name:	**Medicare Number:_____** (Note: may use "member number" instead of "Medicare number")		
Home Phone Number:			
Permanent Street Address (P.O. Box is not allowed)			
City:	[*Optional field:* County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Street Address): Street Address: City: State: ZIP Code:			
Please fill out the following: I am currently a member of the _____ plan in _____<MAO name> with a monthly premium of $_____ . I would like to change to the _____ plan in _____ <MAO name>. I understand that this plan has different health benefits and a monthly premium of $_____ .			
[*Optional Field:* **Name of chosen Primary Care Physician (PCP), clinic or health center:**]			
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ____ <include list of available languages> ____ <include list of other formats (like Braille, audio tape, or large print)> Please contact <plan name> at <phone number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.			

[*Zero premium MA-only plans omit this section*] **Your Plan Premium**
[*Zero premium MA-PD plans insert***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail <***insert optional methods***: "Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example** **"or quarterly">. You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB)**

benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.]

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium [***MA-PD plans with premium insert:* **(including any late enrollment penalty you have or may owe)] by mail** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.**

[*MA-PD plans with premiums also insert:* **If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay [*insert appropriate plan and/or organization name]* the Part D-IRMAA.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

☐ Get a bill <*option: Include other optional methods, such as EFT & credit card*>

☐ Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)]

Please Read This Important Information

[*Insert if enrolling in a PFFS plan:* <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. Your doctor or hospital isn't required to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*Insert if enrolling in a PFFS plan, except for cases in which the member is switching from one PFFS plan to another PFFS plan offered by the same parent organization*: Once <plan name> has your enrollment form, a plan representative will call you. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in <plan name>. If <plan name> isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.]

Please Read and Sign Below:

<Plan> is a plan that has a contract with the Federal government.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be paid based on my enrollment in<plan name>.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [***MA-PD plans insert:*** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***MA PFFS do not include the following paragraph:*** I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information: **Name : _____** **Address: _____** **Phone Number**: (___) ____- _____ **Relationship to Enrollee _____**	

Office Use Only:
Name of staff member/agent/broker (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

[*optional space for other administrative information needed by plan*]

Exhibit 3a: Model Plan Selection Form for MA-PD - Switch From Plan to Plan Within Parent Organization

This form is not applicable to MSA.

Referenced in section(s): 10, 40, 40.1, 40.2

Dear <plan name> Member:

<Introduction - In the introduction of cover letter, MA organization may include language regarding plan choices, description of plans, differences, etc.>. [*Insert to describe PFFS plans:* <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

To make a change in the Medicare Advantage plan you have with <name of MA organization>, fill out the enclosed plan selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us <*optional:* in the postage-paid envelope> by <date>.

Please be aware that you can change health plans only at certain times during the year. Between October 15th and December 7th each year, anyone can join our plan. In addition, from January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you select another plan and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will be <premium amount> and you may continue to see any <current plan name> primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included <year> <Summary of Benefits or benefit overview> for the available options.

If you have any questions, please call <plan name> at <phone number - if plan is planning to have informational meetings - include information about time/place of meetings >. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Plan Selection Form

Date:
Member Name:
Member Number:

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

Please check the appropriate box below <list all available plans>:

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.>

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.>

[Insert to describe PFFS plans: <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*Zero premium MA-only plans omit this section:* **Your Plan Premium**
[*Zero premium MA-PD plans insert***: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail** <*insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month** <*insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.]**

[*MA-only and MA-PD plans with premiums insert***: You can pay your monthly plan premium [***MA-PD plans with premium insert:* **(including any late enrollment penalty you have or may owe)] by mail <***insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month <*optional language in place of "bill each month*": "coupon book" or "payment book">.

Please select a premium payment option:

Receive a bill <*option: Include other optional methods, such as EFT & credit card*>

Automatic deduction from your monthly Social Security or RRB benefit check. (The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)]

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format:

____ <include list of available languages>

____ <include list of other formats (e.g. Braille, audio tape, or large print)>

Please contact <plan name> at <phone number> (TTY users should call TTY number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>.

Signature:	**Today's Date:**
If you are the authorized representative, you must sign above and provide the following information: Name: _____ Address: _____ Phone Number: (___) ____- _____ Relationship to Enrollee _____	

Please mail this form to:
<Insert mailing address>

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request

Referenced in section(s): 40.4.1, 60.4

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show at your doctor appointments until you get your member card from us.] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for enrolling in <Plan name>. Beginning <effective date>, you must get your health care as provided in your *<insert either 'Member handbook' or 'Evidence of Coverage'>*. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But, you shouldn't wait to get this letter before you begin using <plan name> doctors on <effective date>. Also, don't cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[***MA-PD plans with a premium include the following:*** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.]

[*Plans with a premium include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly premium automatically deducted from your Social Security/Railroad Retirement Board benefit check, we may have to send you a bill for your first month or two of enrollment if the

deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.] [*MAOs that disenroll for non-payment of plan premiums include the following sentence:* Members who fail to pay the monthly plan premium may be disenrolled from <plan name>.]

What do I need to know about getting health care services?
You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <plan name>, and we may have to send you a bill for any health care you've received.

[***MA PPO plans do not use the following paragraph:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.]

When can I make changes to my coverage?
Once enrolled in our plan, you can make changes only during certain times of the year. From October 15th through December 7th each year, anyone can make any type of change. From January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.] Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with your prescription drug costs. If you qualify, you may enroll in or disenroll from a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help. If you have more questions about this, please feel free to call <plan name> at <phone number>.

[*MA-PD plans with a premium include the following two paragraphs:*
[*Dual-eligible SNPs may omit the following paragraph*]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

[*Optional*: **What else do I need to know about my coverage?**

If applicable, insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <days/hours of operation and, if different, *TTY* hours of operation>.

Thank you.

Exhibit 4a: Model Notice to Acknowledge Receipt of Completed Enrollment Request – Enrollment in another Plan Within the Same Parent Organization

Referenced in section(s): 40.4.1, 60.4

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for your request to change your enrollment from <old Plan name> to <new Plan name>. Starting <effective date>, you must see your <new Plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <new plan name> doctor(s). You will need to pay your plan copayments at the time you get health care services. [*Optional***:** This letter is proof of health insurance that you should show during your doctor appointments.] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Beginning <effective date>, you must get your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **<***Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>] [***Optional language for MA-PD*:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <new plan name>. But, you shouldn't wait to get this letter before you begin using <new plan name> doctors on <effective date>.

[***MA PPO plans do not use the following sentence:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services**,** if you get health care services from a non-<new plan name> doctor without prior authorization, you will have to pay for these services yourself.]

[*Zero premium plans do not include the following:*
How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for non-payment of plan premium include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[***MA-PD plans with a premium include the following:*** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.]

[*MA-PD plans with a premium include the following two paragraphs:*
[*Dual-eligible SNPs may omit the following paragraph*]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.]

When can I make changes to my coverage?
Once enrolled in our plan, you can make changes only during certain times of the year. From October 15th through December 7th each year anyone can make any type of change. From January 1 through February 14 (except an MSA plan), anyone enrolled in a Medicare Advantage Plan has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.] Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area or want to join a plan in your area with a 5-star rating.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 4b: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment

Referenced in section: 40.4, 60.4

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>.

How will this plan work?
Beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.**

[***MA PPO plans use the following paragraph in place of paragraph above:*** Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Beginning <effective date>, you must get your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] [*Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA-PD plans insert the following two paragraphs if no low-income subsidy:***
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local

Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp. If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[***MA-PD plans add the following paragraph if low-income subsidy applicable:***
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call *<plan name>* at *the phone number provided at the end of this letter*. You can also get information by visiting www.medicare.gov 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.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*:
The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your

monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following:* If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly premium that you owe.]

When can I make changes to my coverage?
Once enrolled in our plan, you can make changes only during certain times of the year. From October 15th through December 7th each year, anyone can make any type of change. From January 1 through February 14 (except an MSA plan), anyone enrolled in a Medicare Advantage Plan has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.] Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*If applicable, please insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]*

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 4c: Model Notice to Acknowledge Receipt of Completed PFFS Enrollment Request

Referenced in section(s): 40.4.1, 60.4

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you will begin to get your healthcare from <plan name>. You must show your <Plan name> ID card to your doctor or hospital before you receive healthcare. You may no longer use your red, white and blue Medicare card to receive healthcare, because **Original Medicare won't pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place.

How will this plan work?
<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. <Plan name> allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except in emergencies. You may contact us at the phone number provided at the end of this letter for help locating another provider in your area. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted*

providers.] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. *Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What should I do now?
Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But you shouldn't wait to get that letter before you begin seeing your <plan name> doctors on <effective date>. Also, don't cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for non-payment of plan premiums include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]
[*MA-PD plans with a premium include the following:* If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly premium that you owe.]

What do I need to know about getting health care services?
You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <plan name>, and we may have to send you a bill for any health care you've received.

When can I make changes to my coverage?
Once enrolled in our plan, you can make changes only during certain times of the year. Between October 15th and December 7th each year, anyone can make any type of change. From January 1 through February 14 (except an MSA plan), anyone enrolled in a Medicare Advantage Plan has an opportunity to disenroll from that plan

and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.] Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*MA-PD plans with a premium include the following two paragraphs:*

What are my costs?

[***MA-PD insert the following if no low-income subsidy:*** The monthly premium for your plan is <insert premium>. *<Explain the charges for which the member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance.>*

[*Dual-eligible SNPs may omit the following paragraph***]**

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 4d: Model Notice to Acknowledge Receipt of Completed PFFS Enrollment Request and to Confirm Enrollment in a PFFS Plan

Referenced in section: 40.4, 60.4

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>.

How will this plan work?
<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. <Plan name> allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except in emergencies. You may contact us at the phone number provided at the end of this letter for help locating another provider in your area.

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. *Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA-PD plans insert the following two paragraphs if no low-income subsidy:***
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp. If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[***MA-PD, if low-income subsidy applicable:***
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call *<plan name>* at *the phone number provided at the end of this letter*. You can also get information by visiting www.medicare.gov 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.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first

eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Zero premium plans do not include the following:*
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for non-payment of plan premiums include the following sentence:* Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following:* If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly plan premium that you owe.]

When can I make changes to my coverage?
Once enrolled in our plan, you can make changes only during certain times of the year. From October 15th through December 7th each year, anyone can make any type of change. From January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [*Plans with drug benefit add this sentence*: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.] Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*If applicable, please insert information instructing member in simple terms how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification*

card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to leave (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 4e: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment in Another Plan Within the Same Parent Organization

Referenced in section: 40.4

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Medicare has approved your enrollment in <new plan name> beginning <effective date>.

How will this plan work?
Beginning <effective date>, you must see your <new plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <new plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.**

[***MA PPO plans use the following paragraph in place of paragraphs above:*** Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Medicare has approved your enrollment in <new plan name> beginning <effective date>. Beginning <effective date>, you must get your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] [*Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[***MA-PD plans insert the following two paragraphs if no low-income subsidy:***
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who

qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp. If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[***MA-PD plans add the following paragraph if low-income subsidy applicable:***
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information we had from your previous enrollment in <old plan name>. If you have questions about the late enrollment penalty, call *<plan name>* at *the phone number provided at the end of this letter.* You can also get information by visiting www.medicare.gov 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.]

[*MA-PD plans insert the following for new members who don't have an existing LEP*:
The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

As you did not previously have a late enrollment penalty with us, you will not have a late enrollment penalty with this enrollment change.]

[*Zero premium plans do not include the following:*

How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.][MAO*s that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following:* If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following:* We will bill you for the portion of your monthly premium that you owe.]

When can I make changes to my coverage?
Once enrolled in our plan, you can make changes only during certain times of the year. From October 15th through December 7th each year, anyone can make any type of change. From January 1 through February 14 (except an MSA plan), anyone enrolled in a Medicare Advantage Plan has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.] Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*If applicable, please insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain Medicare Advantage Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc.]*

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 5: Model Notice to Request Information

Referenced in section(s): 30, 40.2.2

Dear <Name of Member>:

Thank you for applying with <plan name>. We need additional information from you. Please see the checked items below.

We cannot process your application until we get the following things from you:

_____ Proof of Medicare Part A and Part B coverage. Please send us a copy of your Medicare card as proof of your Medicare coverage.

_____ During certain times of the year, Medicare doesn't let you enroll unless you meet certain special exceptions, such as if you qualify for extra help with your prescription drug costs. Please call us at the number below to help us determine if you're able to enroll at this time.

_____ Other: _____

You will need to send this information to <plan name and address> by <date>. You can contact us by phone with this information by calling the phone number below. Or, you may also fax it to us at <fax number> or send it to us at <address>. If we don't get this information by <date>, we will have to deny your request to enroll in our plan.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 6: Model Notice to Confirm Enrollment (MA-PD)

Referenced in section(s): 40.40.2, 40.6

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Please be sure to keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

[I*f no low-income subsidy:*
What are my costs in this plan?
The monthly premium for your plan is: <premium amount>.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name> at the phone number provided at the end of this letter.]

[*If low-income subsidy applicable:*
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[I*nsert the following for new members with an existing LEP:*
Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.] If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.

[I*f previous paragraph not applicable, insert the following for all other new members:* If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?
Now that we have confirmed your enrollment, you may cancel any Medigap policy or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>.We are open <days and hours of operation>.

Thank you.

Exhibit 6a: Model Notice to Confirm Enrollment - Plan to Plan Within Parent Organization

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

Please keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

[*MA-PD, if no low-income subsidy:*
What are my costs in this plan?
The monthly premium for your plan is <premium amount>.

Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please call <plan name> at the phone number provided at the end of this letter.]

[*MA-PD, if low-income subsidy applicable:*
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for members with an existing LEP:* Your premium continues to reflect a late enrollment penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 6b: Model Notice for MA-PD Plans for Individuals Identified on CMS Records As Members of Employer or Union Group Receiving the Retiree Drug Subsidy (RDS)

Referenced in section(s): 40

Dear <Name of Member>:

Thank you for applying with <Plan Name>. To finalize your enrollment, we would like you to confirm that you want to be enrolled in <plan name>.

Medicare has informed us you belong to an employer group or union health plan whose drug coverage is as good as Medicare prescription drug plan coverage.

It is important that you consider your decision to enroll in our plan carefully, since enrollment in <plan name> could affect your employer or union health benefits. You could lose your employer or union health coverage. If you haven't already done so, please contact your benefits administrator to discuss your decision to enroll in a Medicare prescription drug plan.

[*PFFS plans insert*: <Plan Name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

If you have already discussed this decision with your benefits administrator and have decided that you would still like to be a member of <plan name>, **please call** <plan name> **at the phone number provided below. Your enrollment won't be complete until you call and confirm this information.** Your effective date will be <effective date>.

We must hear from you to enroll you in our plan. If we don't hear from you within 30 days from the date of this notice, we won't process your enrollment. If you decide not to enroll in <plan name> you will be responsible for any services you have already received from <plan name>.

To confirm your enrollment or if you have any questions, please feel free to contact <plan name> at <phone number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 6c: Model Notice to Confirm PFFS Enrollment

Referenced in section: 40.4.2

<Member # >
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. You must show your <Plan name> ID card to your doctor or hospital before you get healthcare. Don't use your red, white, and blue Medicare card to receive healthcare, because **Original Medicare won't pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place. [*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] [*Optional language for MA-PD***:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

How does this plan work?
<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. As we told you before, <Plan name> allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except for emergencies. You may contact us at the number at the end of this letter for help locating another provider in your area.

[*Include if plan uses a network of contracted providers:* <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [*Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.*] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our

terms and conditions of payment. [*Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.*]

[*MA-PD, if no low-income subsidy:*
What are my costs in this plan?
The monthly premium for your plan is <premium amount>. [*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

[*MA-PD, if no low-income subsidy:*
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name> at the phone number provided at the end of this letter.]

[*MA-PD, if low-income subsidy applicable:*
What are my costs since I qualify for extra help?
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[*MA-PD plans insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[*MA-PD plans, if previous paragraph not applicable, insert the following for all other new members*: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 6d: Model Notice to Confirm Enrollment (MA-only)

Referenced in section(s): 40.4.2

<Member # >

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Please be sure to keep a copy of this letter for your records.

What are my costs in this plan?

[*MA-only plans with a premium insert the following:*
The monthly premium for your plan is: <premium amount>.]

[*Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance*]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?
Now that we have confirmed your enrollment, you may cancel any Medigap policy or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>.We are open <days and hours of operation>.

Thank you.

Exhibit 7: Model Notice for MA Organization Denial of Enrollment

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

Thank you for applying with <MA Plan>. We cannot accept your request for enrollment in <MA Plan> because:

1. _____ You don't have Medicare Part A.

2. _____ You don't have Medicare Part B.

3. _____ You have End Stage Renal Disease (ESRD).

4. _____ Your permanent residence is outside our service or continuation area.

5. _____ You attempted to enroll outside of an enrollment period.

6. _____ We didn't get the information we requested from you within the timeframe listed in our request.

7. _____ The request was made by someone other than the beneficiary and that individual isn't the beneficiary's authorized representative.

[8. _____ ***MA-PD plans only:*** You are not eligible to enroll in prescription drug coverage at this time.]

[9._____ ***MA-PD plans only:*** You have drug coverage from your employer or union and you told us you don't want to join <MA plan>.]

[10. _____ ***Special needs plans only:*** You are not eligible for this Special Needs Plan because you don't <insert special needs criteria>.]

If <plan name> paid for any of your health care services, then we will bill you for the amount paid.

If item 5 [*MA-PD plans insert*: or item 8] is checked, remember that you can make changes to your coverage only at certain times during the year. Between October 15th and December 7th each year anyone can make any type of change including adding or dropping Medicare prescription drug coverage. From January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with your prescription drug costs.

[Dual-eligible SNPs may omit the following two paragraphs:
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.]

If you believe any of the checked items are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 8: Model Notice for CMS Rejection of Enrollment

Referenced in section(s): 40.4.2

Dear <Name of Beneficiary>:

[*If sending in place of combined acknowledgement/confirmation notice, insert the following sentence*: Thank you for your request to enroll in <plan name>.] Medicare has denied your enrollment in <MA Plan> due to the reason(s) checked below:

1. _____ You don't have Medicare Part A

2. _____ You don't have Medicare Part B

3. _____ You have End Stage Renal Disease (ESRD)

4. _____ You attempted to enroll outside of an enrollment period.

5. _____ You requested to enroll in a different plan for the same effective date, which canceled your application with <plan name>.

If <plan name> paid for any of your health care services, then we will bill you for the amount paid.

If item 4 is checked, remember that you can make changes to your coverage only at certain times during the year. From October 15th through December 7th each year, anyone can make any type of change including adding or dropping Medicare prescription drug coverage. From January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. Generally, you may not make changes at other times unless you meet certain special exceptions, like if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with your prescription drug costs.

[Dual-eligible SNPs may omit the following two paragraphs:
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.]

If you believe any of the checked items are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 9: Model Notice to Send Out Disenrollment Form (MA-PD enrollee)

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from <plan name>.

When can I make changes to my Medicare coverage?
You can make plan changes, such as requesting disenrollment, only at certain times during the year. From October 15th through December 7th each year, anyone can make any type of change including adding or dropping Medicare prescription drug coverage. From January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.]. Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with your prescription drug costs. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What is extra help?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

When should I fill out the disenrollment request form?

- You **should** fill out the attached form if you want to change to Original Medicare only and do not want Medicare prescription drug coverage.
- You **shouldn't** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage plan or other Medicare health plan. Enrolling in another Medicare plan will automatically disenroll you from our plan.
- You **shouldn't** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.

Until your disenrollment date, you must keep using <plan name> doctors. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <plan name>'s network.

How do I submit the disenrollment request?

If you want Original Medicare, as described above, you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can call 1-800-MEDICARE (1-800-633-4227) for information about Medicare plans available in your area. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

What are my Medigap rights?

If you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap policy, also known as Medicare supplemental insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information about trial periods. TTY users should call 1-877-486-2048.

If you need any help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Attachment

Exhibit 9a: Model Notice to Send Out Disenrollment Form (MA-only enrollee)

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from <plan name>.

When can I make changes to my Medicare coverage?
You can make plan changes, such as requesting disenrollment, only at certain times during the year. From October 15th through December 7th each year, anyone can make any type of change including adding or dropping Medicare prescription drug coverage. From January 1 through February 14, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with your prescription drug costs. If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help

[*Dual eligible Special Needs Plans may omit this* paragraph: **What is extra help?**
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

When should I fill out the disenrollment request form?
You **should** fill out the attached form if you want to change to Original Medicare only and don't want Medicare prescription drug coverage.

You **shouldn't** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage or other Medicare Health Plan. Enrolling in another Medicare plan will automatically disenroll you from <plan name>.

[*MA-only coordinated care plans insert:* You **shouldn't** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.]

[*MSA plans insert:* Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA

Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

Until your disenrollment date, you must keep using <plan name> doctors. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <plan name>'s network.

How do I submit the disenrollment request?
If you want Original Medicare, as described above, you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for information about Medicare plans available in your area. TTY users should call 1-877-486-2048.

What are my Medigap rights?
If you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you need any help, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Attachment

Exhibit 10: Model Disenrollment Form

Referenced in section: 10

If you request disenrollment, you must continue to get all medical care from <plan name> until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of <plan name>'s network. We will notify you of your effective date after we get this form from you.

Last name: First Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.
Medicare #			
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )	

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in <MA plan name> on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Your Signature*: _____ Date: _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by <plan name> or by Medicare.

If you are the authorized representative, you must provide the following information:

Name : _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Exhibit 10a: Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

Referenced in section: 30.4

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Disenrollment Period from January 1 through February 14 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I get extra help paying for Medicare prescription drug coverage.
- ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I am joining a PACE program on (insert date) _____.
- ☐ I am joining employer or union coverage on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact <plan name> at <phone number> (TTY users should call <TTY number>) to see if you are eligible to disenroll. We are open <insert days and hours of operation>.

Exhibit 11: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

Referenced in section(s): 50.1, 50.1.4, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <plan name>. You will be disenrolled starting <effective date.> Beginning <effective date>, <plan name> won't cover any health care you get. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans insert:* When coverage from <plan name> ends, your <plan name> prescription drug coverage ends too. **If you don't take any action, you will be covered by Original Medicare beginning <effective date>.** To have new health care coverage and prescription drug coverage on <effective date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. For example, if you are returning to Original Medicare and want Medicare prescription drug coverage, you must join a Medicare prescription drug plan. If you don't enroll in a Medicare prescription drug plan on your own and you have both Medicare and Medicaid, Medicare will enroll you in a Medicare prescription drug plan, unless you tell the plan you don't want to join. If you don't enroll in another Medicare Advantage plan with prescription drug coverage or Medicare prescription drug plan, or if you don't get creditable coverage as good as Medicare prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*MA-only plans insert:* Disenrolling from <plan name> doesn't affect any prescription drug coverage you may have. To have new health care coverage on <effective date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. If you don't take any action, you will be covered by Original Medicare beginning <effective date>.]

[*MSA plans insert the following*: Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

Please be patient. It will take a few weeks for us to process your disenrollment and update Medicare's records. If your doctors need to send Medicare claims, you may want to tell them that you just disenrolled from <plan name> and there may be a short delay in updating your records.

Information About Medigap Rights

If you will be changing to Original Medicare you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your

State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you need any help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

[*Dual eligible Special Needs Plans may omit this* paragraph: Did you know that people with limited incomes may qualify for extra help to pay for their prescription drug costs? If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

Thank you.

Exhibit 11a: Model Notice to Request Information (Disenrollment)

Referenced in section(s): 30, 50.4.2

Dear <Name of Member>:

We received your request to disenroll from <plan name>. However, it is missing information that will help us to determine if we can accept your request. We cannot process your disenrollment without this information.

Please review the checked item(s) below and contact us immediately.

_____ Medicare requires that you sign your written disenrollment request. The request we received from you didn't include a signature. Please call us at the number below to confirm that you want to disenroll from <plan name>.

_____ During certain times of the year, Medicare doesn't let you disenroll unless you meet certain special exceptions, such as if you qualify for extra help with your prescription drug costs. Please call us at the number below to help us determine if you're able to disenroll at this time.

_____ The request we received was from someone other than you and that individual isn't listed as your authorized representative. Please call us at the number below so that we may confirm your request to disenroll.

_____ Other: _____

If you have any questions about the information in this letter or would like to provide us with information to help us process your disenrollment request, you may contact us by telephone or mail:

<plan name>
<mailing address>
<toll free number and days/hours of operation)
<TTY toll-free number>

You may also fax us information at <fax number>.

If we don't get this information, we will have to deny your request to disenroll from our plan.

Instead of sending a disenrollment request to <plan name> you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week to disenroll by telephone. TTY users should call 1-877-486-2048. If you're receiving coverage through your employer, you should contact your employer instead of calling 1-800-MEDICARE to find out how this affects your retiree benefits.

Thank you.

Exhibit 12: Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)

Referenced in section(s): 50.1, 50.4.1, 60.3.2

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <MA Plan>. Beginning <effective date,> <plan name> won't cover your health care. If your doctor needs to send Medicare claims, you may want to tell them that there may be a short delay in updating your records since you recently disenrolled from <plan name>.

[*MA-PD plans insert the following*: If your <plan name> premium is being deducted from your Social Security or Railroad Retirement Board benefit, please allow up to 3 months for Social Security or the Railroad Retirement Board to process a refund. If you have not received a refund within 3 months of this letter, you should contact 1-800-MEDICARE.]

[*MSA plans insert the following*: Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

INFORMATION ABOUT MEDIGAP RIGHTS

If you will be changing to Original Medicare you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you think you didn't disenroll from <plan name>, and you want to keep being a member of <plan name>, please call us right away at <phone number> so we can make sure you stay a member of <plan name>. Medicare gives you only 30 days from the date of this letter to contact us. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

[*Dual eligible Special Needs Plans may omit this* paragraph: Did you know that people with limited incomes may qualify for extra help to pay for their prescription drug costs? If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.]

Thank you.

Exhibit 12a: Model Notice for MA Organization Denial of Disenrollment

Referenced in section: 50.1.4

Dear <Name of Beneficiary>:

We recently got your request to disenroll from <plan name>. We cannot accept your request for disenrollment because:

1. _____ You have attempted to make a change outside of an enrollment period.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below).

3. _____ We didn't get the information we requested from you within the timeframe listed in our request.

4. _____ The request was made by someone other than the enrollee and that individual isn't the enrollee's authorized representative.

When can I make changes to my coverage?
There are limits to when and how often you can change the way you get Medicare.

- **From October 15 through December 7,** anyone with Medicare can switch from one way of getting Medicare to another, including adding or dropping Medicare prescription drug coverage.
- **From January 1 through February 14,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.]

Generally, you may not make any other changes during the year unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with your prescription drug costs. If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[Dual-eligible SNPs may omit the following paragraph:]
What is extra help?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local

Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you believe any of the items we checked are wrong, or if you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 12b: Model Notice for CMS Rejection of Disenrollment

Referenced in section: 50.1

Dear <Name of Beneficiary>:

Medicare has denied your disenrollment from <plan name> due to the reason(s) checked below:

1. _____ You have attempted to make a change outside of an enrollment period.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

When can I make changes to my coverage?
There are limits to when and how often you can change the way you get Medicare.

- **From October 15 through December 7**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including adding or dropping Medicare prescription drug coverage.

- **From January 1 through February 14,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.]

Generally, you may not make any other changes during the year unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or if you qualify for extra help with your prescription drug costs. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*Dual-eligible SNPs may omit the following paragraph***:]**
What is extra help?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you believe any of the items we checked are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 13: Model Notice of Disenrollment Due to Death

Referenced in section(s): 50.2.3, 50.4.2, 60.3.1

To the Estate of <Member Name>:

Medicare told us of the death of <Member's Name>. Please accept our condolences.

<Member's name>'s coverage in <plan name> [ended; will end] as of <effective date>. If plan premiums were paid for any month after <effective date>, we will issue a refund to the Estate within 30 days of this letter.

[*MA-PD plans insert the following*: If the <plan name> premium is being deducted from <Member Name>'s Social Security or Railroad Retirement Board benefit, please allow up to 3 months for Social Security or the Railroad Retirement Board to process a refund. If the estate has not received a refund within 3 months of this letter, a representative of the estate should contact 1-800-MEDICARE anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[*MSA plans insert the following*: Please note that the Estate has to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time of enrollment. The amount owed is based on the number of whole months left in the year after the date of death.]

If this information is wrong, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 14: Model Notice of Disenrollment Due to Loss of Medicare Part A and/or Part B

Referenced in section(s): 50.2.2, 50.4.2, 60.3.1

Dear <Name of Member>:

Medicare has told us that you [will] no longer have Medicare Part <insert A and/or B, as appropriate>. You need to have coverage under both Medicare Part A and Part B to remain enrolled in a Medicare Advantage plan. Therefore, your membership in <plan name> [ended; will end] on <date>. If this information is wrong, and you want to stay a member of our plan, please contact us. Also, if you haven't already done so, please contact your local Social Security office to have their records corrected.

[*MA-PD plans insert*: When coverage from <plan name> [ends; ended] on <date>, your Medicare prescription drug coverage [will end; ended] too. If you still have either Medicare Part A or Medicare Part B you are eligible for Medicare prescription drug coverage. To get Medicare prescription drug coverage, you must enroll in a Medicare prescription drug plan such as a Medicare Advantage Plan with prescription drug coverage or a Medicare Prescription Drug Plan. If you are eligible to join a Medicare prescription drug plan but don't join, and you don't have other drug coverage that is at least as good as Medicare's, you may have to pay a late enrollment penalty if you join later. This means you pay a higher premium for as long as you have Medicare prescription drug coverage. Remember, Medicare limits how and when you can make changes to your coverage. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 15: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

Medicare records incorrectly show you as deceased.

If you haven't already done so, please go to your local Social Security Office and ask them to correct your records. Please send us written proof at <address> after you do this. When we get this proof, we will share it with Medicare.

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. MA plans may insert "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate.] If you have any questions or need help, please call us at < phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 16: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination

Referenced in section(s): 60.3, 60.3.1

Dear < Name of Member>:

On <date of request> you told us that your enrollment in Medicare was ended in error and that you want to stay a member of <plan name>.

[*Organizations that are able to verify current Medicare entitlement may omit the following*:
To do this, please complete the following three steps no later than <insert date: 60 days from date of disenrollment notice>:

1. Contact Social Security at 1-800-772-1213 between 7AM to 7PM, Monday to Friday, to have them fix their records TTY users should call 1-800-325-0778.

2. Ask Social Security to give you a letter that says they have fixed your records.

3. Send the letter from Social Security to us at: <address of MA Plan> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we get this letter, we will tell the Medicare to correct its records.]

[*Organizations that are able to verify current Medicare entitlement insert*: Social Security corrected the error. We will tell Medicare to correct its records.]

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. MA plans may insert “physicians” or “doctors” or “providers” instead of “primary care physician,” if that is more appropriate.]

[*Organizations that are able to verify current Medicare entitlement omit the following*:
If we find out that you don’t have Medicare Part <insert “A” and/or “B” as appropriate>, or if we don’t get proof that you have Medicare by <insert date: 60 days from date of disenrollment notice>, you will have to pay for any service you got after <disenrollment date>.]

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error

Referenced in section(s): 60.3, 60.3.3

Dear <Name of Member>:

Thank you for letting us know that you want to remain a member of <plan/sponsor name> after we mistakenly [*select one based on the circumstance:* disenrolled you from/cancelled your enrollment in] our plan. [*Insert brief summary of the plan error that caused the disenrollment.]* We apologize for the inconvenience. We have changed our records to show that you are still a member of <plan/sponsor name>. You should keep seeing your <plan name> [*insert appropriate term*: <primary care physician, physicians, doctors, providers, pharmacies, etc.] for your health care.

If you have any questions or need help, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 18: Model Notice to Close Out Request for Reinstatement

Referenced in section(s): 60.3.2

Dear <Name of Beneficiary>:

We cannot process your request to be in <plan name> again because we haven't gotten the information we requested. As discussed in our letter of <date of letter> you must send us this information by <date placed on notice in Exhibit 16> to remain a member of our plan.

You were no longer a member of our plan as of <effective date>. If <plan name> paid for any services after this disenrollment date, we will have to bill you for those services.

If you have any questions, please call <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage of Optional Supplemental Benefit(s)

Referenced in section: 50.3.1

Dear <Name of Member>:

Our records show that we haven't gotten payment for your plan premium as of <premium due date>.

[*MA organizations who will disenroll all members (and not use the downgrade option) use the following sentences:* If we don't get payment by <date grace period expires>, we will have to disenroll you from <plan name>, effective <disenrollment date>. After <disenrollment date> you will be covered by Original Medicare instead of <plan name>.]

[*Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent disenrollment.*]

[*MA organizations who will reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefit(s) use the following sentences:* If we don't get payment by <date grace period expires>, we will make some changes to your membership in <plan name> that will reduce the amount of health care coverage you have in <plan name>. This means that <describe lower level of benefits, e.g., routine dental care will not be covered> beginning <date>.]

[*Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent the downgrade.*]

[*Insert if applicable in state where member resides:* If you get medical assistance (Medicaid) from your State (including paying your premiums, deductibles, or coinsurance), you should check with your State Medicaid Agency to find out if they have been paying for, or have stopped paying for, your plan premium. If you are no longer eligible for assistance from Medicaid, you may have a special temporary right to buy a Medigap policy if you voluntarily disenroll from our plan. If you have questions about Medigap policies, you should contact your State Health Insurance Program, <name of SHIP>, at <SHIP phone number(s)> to get more information.]

If you wish to disenroll from <plan name> and change to Original Medicare now, you should do one of these two things:

1. Send us a written request at <MA Plan address>.

2. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Remember, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including adding or dropping Medicare prescription drug coverage.
- **From January 1 through February 14,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.].

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage. If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[Dual-eligible SNPs may omit the following paragraph:]
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you paid the premium recently and you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 20: Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment

Referenced in section(s): 50.3.1

Dear <Name of Member>:

On <date> we sent you a letter that said your plan premium was overdue. The letter said that if we didn't get payment from you, we would disenroll you from <plan name>. Since we didn't get that payment, we asked Medicare to disenroll you from <plan name> beginning <effective date>. You will be covered by Original Medicare beginning <effective date>.

[***MA PFFS do not include this paragraph:*** Please note that until <disenrollment effective date>, you must keep using <plan name> doctors except for emergency or urgently needed care or out-of-area dialysis services. After that date, you can see any doctor through Original Medicare, unless you join a Medicare Advantage plan or another Medicare health plan.]

What if I think there's been a mistake?
If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <*insert* "Member Handbook" *or* "Evidence of Coverage," *as appropriate*>.

I had an emergency that kept me from sending my payment. What can I do?
You can ask Medicare to review this decision if you can show "good cause" (a good reason) for not paying your premiums. A good reason would have to be an emergency or unexpected situation. If Medicare approves your request, you will have to pay all owed premium amounts within 3 months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week, to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

[***MA-PD plans insert:*** Please remember, if you don't have or get other creditable coverage (as good as Medicare prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph*:]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly

prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

For more information:
If you have any questions or if you have recently sent us a payment, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 21: Model Notice on Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment

Referenced in section(s): 50.3.1

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <plan name> because you didn't pay your plan premium *[For situations where the disenrollment effective date for failure to pay plan premiums and failure to pay Part D-IRMAA are the same, MA-PD plans who use this one notice to convey both actions must insert:* and your Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)*]*. Your disenrollment begins <effective date>. You are now enrolled in Original Medicare.

What if I think there's been a mistake?
If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <*insert* "Member Handbook" *or* "Evidence of Coverage," *as appropriate*>.

I had an emergency that kept me from sending my payment. What can I do?
You can ask Medicare to review this decision if you can show "good cause" (a good reason) for not paying your premiums. A good reason would have to be an emergency or unexpected situation. If Medicare approves your request, you will have to pay all owed premium amounts within 3 months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week, to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

When can I make changes to how I get my Medicare coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

[*MA-PD plans insert:* Please remember, if you don't have or get other creditable coverage (as good as Medicare prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph*:]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local

Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

For more information:
If you have any questions, or need help, please call <plan name> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 21a: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount

Referenced in section: 50.2.6

Important – You have been disenrolled from your Medicare Advantage Prescription Drug Plan

<Date>

Dear <Beneficiary Name>:

Medicare has disenrolled you from <MA-PD plan name> because you didn't pay the extra amount (called the Part D-Income Related Monthly Adjustment Amount or Part D-IRMAA). As of <effective date>, you will no longer have coverage through <MA-PD plan name>. Your Medicare prescription drug coverage ended on the same date. Since the disenrollment has already processed, you can't pay the owed amounts now to keep your Part D coverage.

Before you were disenrolled, Medicare (or the Railroad Retirement Board) sent you notices that showed the amount that you owed and provided information on how to pay this amount. If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, not by <plan name>.

What if I think there's been a mistake?
If you paid the Part D-IRMAA or think that there has been a mistake, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

I had an emergency that kept me from sending my Part D-IRMAA payment. What can I do?
You can ask Medicare to review this decision if you can show "good cause" (a good reason) for not paying your premiums. A good reason would have to be an emergency or unexpected situation. If Medicare approves your request, you will have to pay all owed plan premium amounts and all owed Part D-IRMAA amounts within 3 months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week, to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

Please remember, if you don't request reinstatement within 60 days and pay all owed amounts within 3 months, you will not get your coverage back and will have to wait for another opportunity to enroll. If you don't get your coverage back and go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty in addition to the monthly Part D-IRMAA and plan premium, if you enroll in Medicare prescription drug coverage in the future.

When can I get Part D coverage?
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 of each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

Who can I call to get more information?
You can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week if you have questions about your disenrollment because you didn't pay the Part D-IRMAA. TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions about your plan's premium. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 22: Model Notice on Failure to Pay Optional Supplemental Benefit Premiums - Notice of Reduction in Coverage of Optional Supplemental Benefit(s) Within the Same Plan (PBP)

Referenced in section(s): 50.3.1

Dear <Name of Member>:

We recently sent you a letter dated <date> that said your plan premium was overdue. The letter said that if we didn't get payment from you, we would have to make some changes in your membership in <plan name>. Our records show that we did not get payment from you as of <date>. Therefore, we have reduced your coverage in <plan name>, beginning <effective date>.

<Explain in simple terms lower level of benefits, e.g., routine dental care won't be covered>

You have the right to ask us to reconsider this change through the grievance procedure written in your <insert "Member Handbook" or "Evidence of Coverage", as appropriate>.

If you want to disenroll from <plan name> and return to Original Medicare now, you should do one of these two things:

1. Send us your written request to <plan name> or fax it to us at <fax number>.
2. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

Remember, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7,** anyone with Medicare can switch from one way of getting Medicare to another for the following year, including adding or dropping Medicare prescription drug coverage.
- **From January 1 through February 14,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.]

Generally, you will be able to make changes only during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with prescription drug costs. If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*Dual-eligible SNPs may omit the following paragraph*:]

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 22a: Model Notice on Favorable "Good Cause" Determination – Notification of Premium Amount Due for Reinstatement

Referenced in section: 60.3.4

Dear <Name of Member>:

Medicare has notified us that you have received a favorable decision regarding your request for reinstatement into <plan name>. Our records show that we haven't gotten payment for your plan premium as of <premium due date>. In order for your coverage to be reinstated, we must receive payment in the amount of <enter amount owed> no later than <date 3 months from the effective date of disenrollment>.

[*MA organizations that will disenroll all members (and not use the downgrade option) use the following sentences:* If we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>. You will be covered by Original Medicare instead of <plan name>.]

[*MA organizations who will reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefit(s) insert the following sentences:* If we don't get payment by < date 3 months from the effective date of disenrollment >, you will continue to have a reduced amount of health care coverage in <plan name>. This means that <describe lower level of benefits, e.g., routine dental care will not be covered>.

[*MA organizations may elect to mail a payment coupon with the letter. MA organizations that include the coupon with the letter, insert the following sentences:* You can mail your payment to us using the enclosed coupon. Be sure to make full payment of your owed amount and include your member number on the check.]

[*MA organizations that do not include a payment coupon with the letter, insert the following sentences:* You can mail your payment to us at the following address: <billing address>. Be sure to make full payment of your owed amount and include your name and [*insert* one: member number/billing number/ID number] on the check.]

[*If disenrollment was due to failure to pay Part D-IRMAA premiums and the beneficiary also owed the MA organization premiums, insert the following sentences:* In addition to the plan premiums you owe, you must also pay <Medicare or RRB> your amount due for the Part D-Income Related Monthly Adjustment Amount. <Medicare or RRB> will send you a letter regarding the amount you owe and how you can pay. You must pay <Medicare or RRB> this amount by <date 3 months from the effective date of disenrollment> to be reinstated.]

Remember, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including adding or dropping Medicare prescription drug coverage.

- **From January 1 through February 14,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. [Plans with drug benefit: If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.].

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help paying for prescription drug coverage. If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[Dual-eligible SNPs may omit the following paragraph:]
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Thank you.

Exhibit 23: Model Notices for Closing Enrollment

Referenced in section(s): 30.8.1

Model A: Closing Enrollment for Partial Month(s)

<MA organization> PUBLIC NOTICE

As of <date> <MA organization> will no longer offer continuous open enrollment under its Medicare Advantage contract with Medicare for <plan name> in <service area>.

Instead, <MA organization> will offer open enrollment for all eligible individuals from the <insert date> to the <insert date> of each month.

<MA organization> will continue to accept enrollments into <plan name> during an entire month from people who meet certain special exceptions, such as if someone moves out of the plan's service area or qualifies for extra help with prescription drug costs..

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals from October 15 through December 7.

Current members of <plan name> aren't affected by this change. For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call<TTY number>.

Thank you.

Model B: Closing Enrollment for Whole Month(s)

<MA organization> PUBLIC NOTICE
As of <date> <MA organization> will no longer offer open enrollment under its Medicare Advantage contract with Medicare for <plan name> in <service area>.

However, <MA organization> will continue to accept enrollments into <plan name> from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals during the Annual Election Period from October 15 through December 7.

Current members of <plan name> aren't affected by this change. For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. Thank you.

Model C: Closing Enrollment for Capacity Reasons

<MA organization> PUBLIC NOTICE

As of <date>, <MA organization> will no longer accept enrollment under its Medicare Advantage contract with Medicare for <plan name> in <insert service area>.

<MA organization> is limiting enrollment in <plan name> so plan members have greater access to providers and services.

Current members of <plan name> aren't affected by this change. Also, individuals who are enrolled in other <MA organization> plans may still be able to enroll in <plan name> when they become eligible for Medicare.

For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 24: Model Notice for Medigap Rights Per Special Election Period

Referenced in section(s): 50.1 and 50.2

Dear <Name of Beneficiary>:

This is to confirm that you disenrolled from <plan name> effective <date> and returned to Original Medicare because of the special circumstances indicated below:

_____ You permanently moved.

_____ You get help from the Medicaid program.

_____ You wanted to use certain Medigap protections while in your trial period.

_____ Other circumstances defined as eligible for a Special Election Period.

Please save this letter as proof of your Medigap rights.

[**Information about Medigap rights**
Since you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap (Medicare supplement insurance) policy, even if you have health problems. For example, if you are age 65 or older, and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. Your State may have laws that provide more Medigap protections. If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.]

If you have any questions, please call us at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 25: Acknowledgement of Request to Cancel Enrollment

Referenced in section(s): 60.2.1

Dear <name of applicant>:

As requested, we have cancelled your request to enroll with <plan name>.

Please be patient. It may take up to 45 days for Medicare to update your records. If you are in Original Medicare, you may want to tell your doctors that if they need to submit Medicare claims, there may be a short delay in updating your records.

Important: If you were enrolled in another Medicare Advantage plan or Medicare prescription drug plan before enrolling with <plan name>, you should be automatically enrolled back into that plan.

If you don't receive an enrollment acknowledgement letter from your previous plan within two (2) weeks of receiving this letter, please contact them to confirm your enrollment. They may request a copy of this letter for their records.

Please remember that if you don't have or get Medicare prescription drug coverage or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

[*Dual-eligible SNPs may omit the following two paragraphs*:
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.]

If you have any questions, please contact <plan name> at <number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 25a - Model Acknowledgment of Reinstatement

Dear <member name>:

Please be sure to keep a copy of this letter for your records.

Medicare has enrolled you back in <plan name> with no break in coverage as of <effective date>.

[*If PCP not applicable, omit following sentence. Terms such as "physicians" or "doctors" or "providers" may be used instead of "primary care physician":* You should keep using your <plan name> primary care physician for your health care.]

[*Insert one of the following sentences depending on plan policy:* We will be sending you a new membership card and other important documents for <plan name>. *or* You can continue using the <plan name> membership card that you currently have. *or* If you no longer have your membership card, contact us at the number below to get a new card.]

[*Insert information regarding plan premiums required to maintain enrollment, or use the following language:* The monthly premium for <plan name> is <monthly premium amount>. You must pay this premium amount each month to remain enrolled in our plan. For more information regarding our disenrollment policy for non-payment of plan premiums, please see our policy written in your <insert "Member Handbook" or "Evidence of Coverage", as appropriate>.]

Please call <plan name> at <phone number> if you have any questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you for your continued membership in <plan name>.

Exhibit 26: Acknowledgement of Request to Cancel Disenrollment

Referenced in section(s): 60.2.2

Dear <name of member>:

As requested, we have cancelled your disenrollment with <plan name>. [*If PCP not applicable, omit following sentence. Terms such as "physicians" or "doctors" or "providers" may be used instead of "primary care physician":* You should keep using your <plan name> primary care physician for your health care.] Thank you for your continued membership in <plan name>.

IMPORTANT: If you have also enrolled in another Medicare Advantage plan or Medicare Cost plan or Medicare Prescription Drug Plan, you may appear on their records as being enrolled. If you want to stay enrolled in <plan name>, you will need to notify the other Medicare plan that you are canceling enrollment in their plan before that enrollment takes effect. They may request you write them a letter for their records.

If you have any questions, please contact <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 27: MA Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in MA-PD Plan

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. [*Insert for those with retroactive effective dates:* To make sure that you don't lose a day of your drug coverage,] [*Insert for those with prospective effective dates:* To make sure you have prescription drug coverage,] Medicare has asked us to enroll you in our <MA-PD plan name> that includes Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

Starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <plan name> doctor(s). You will need to pay our copayments when you get health care. [*Optional:* This letter is proof of insurance that you should show during your doctor appointments**.**] [*Optional*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What are my costs in this plan?
With this Medicare prescription drug coverage, you will pay no more than:

- $0 for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by the plan.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

[*Include cost of premium less low-income premium subsidy amount, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.*]

What do I need to know about getting health care services?
[***MA PPO and PFFS plans do not use the following paragraph:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care from a non-<new plan name> doctor without prior authorization, you will have to pay for the health care yourself.]

[***MA PPO plans use the following paragraph*:** Beginning <effective date>, you will get your health care as provided in your *<insert either "Member handbook" or "Evidence of Coverage''>*. You

will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[***MA PFFS plans use the following paragraph:*** Beginning <effective date>, you will begin to receive your healthcare from <new plan name>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. <new plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital doesn't have to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

What if Medicaid used to pay for my prescription drugs?
Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <new plan name>.

What if I have other prescription drug coverage?
If you now have drug coverage through an employer or union plan, joining a Medicare drug plan may NOT be right for you. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family current coverage. You may not need to join a Medicare drug plan. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy.

What if I want to join another plan?
You aren't required to be in our Medicare prescription drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare prescription drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

What if I don't want Medicare prescription drug coverage?
If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> within 10 days of the date on this letter. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 27a: MA-PFFS Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. To make sure you have prescription drug coverage. Medicare has asked us to enroll you in our <PDP name> that provides Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

How does this plan work?
Starting <effective date>, all of your health care will continue to be covered under your <current MA-only plan name> and your prescription drug coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan> won't change. **[Optional:** You will be sent a membership card along with more detailed information about your prescription drug coverage in the next several days. Until you get your prescription drug card, you can use this letter to buy your prescriptions.]

With the addition of this Medicare prescription drug coverage, you will pay no more than:

- $0 for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by the plan.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

There will be no changes to your premium, medical benefits or member copayments under the <current MA-only plan name>.

What if Medicaid used to pay for my prescription drugs?
Remember, Medicaid won't pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>.

What if I have other prescription drug coverage?
If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I paid for drugs before my new coverage starts?
If you filled any covered prescriptions before <effective date>, you might be able to get back part of what the prescriptions cost if you were eligible for Medicare and Medicaid but not enrolled in a Medicare drug plan. Call Medicare's Limited Income NET program at 1-800-783-1307. TTY users should call *711*~~1-877-301-0369~~. You can also visit www.humana.com/pharmacists.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?
You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> within 10 days of the date on this letter. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment into MA-PD plan

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs. Medicare has asked us to enroll you in our <MA-PD plan name> that offers Medicare prescription drug coverage beginning <effective date>, unless you tell us you don't want to join our plan.

[***MA PPO and PFFS plans do not use the following paragraph:*** Starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <MA-PD plan name> doctor(s). You will need to pay our copayments when you get health care.]

[*Optional:* This letter is proof of insurance that you should show during your doctor's appointments until you get your member card from us**.**] [*Optional*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What are my costs in this plan?
With Medicare prescription drug coverage, you will pay no more than:

- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by our plan.

[*Include cost of premium less amount of premium assistance for which the member is eligible, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.*]

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

What do I need to know about getting health care services?
[***MA PPO and PFFS plans do not use the following paragraph:*** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care from

a non-<MA-PD plan name> doctor without prior authorization, you will have to pay for the health care yourself.]

[***MA PPO plans use the following paragraph:*** Beginning <effective date>, you will get your health care as provided in your *<insert either "Member handbook" or 'Evidence of Coverage'>*. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[***MA PFFS plans use the following paragraph:*** Beginning <effective date>, you will begin to receive your healthcare from <new plan name>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. <MA-PFFS plan name>, a Medicare Advantage Private Fee-for-Service Plan, works differently than Original Medicare. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

What if I have other prescription drug coverage?
If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?
You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> before <effective date>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 28a: MA Model Notice to Inform Member of Facilitated Enrollment into PDP

Referenced in section: 40.1.5

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs . To make sure you have prescription drug coverage, Medicare has asked us to enroll you in our <name of PDP> that provides Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

Starting <effective date>, all of your health care, will continue to be covered under your <current MA-only plan name>, and your pharmacy coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan name> won't change. [*Optional:* You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]

With the addition of this Medicare prescription drug coverage, you will pay no more than:

- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that the extra help amounts should be different, please contact <plan name> at the phone number provided at the end of this letter.

There will be no changes to your premium, medical benefits or member copayments under <current MA-only plan name>.

What if I have other prescription drug coverage?
If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a

Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I paid for drugs before my new coverage starts?
If you filled any covered prescriptions before <effective date>, you might be able to get back part of what the prescriptions cost if you were eligible for Medicare and Medicaid but not enrolled in a Medicare drug plan. Call Medicare's Limited Income NET program at 1-800-783-1307. TTY users should call *711*~~1-877-301-0369~~. You can also visit www.humana.com/pharmacists.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?
You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> before <effective date>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 29: Acknowledgement of Request to Opt Out of Auto/Facilitated Enrollment

Referenced in section(s): 40.1.5

Dear <name of member>:

As requested, we have processed your request to decline (opt out of) Medicare prescription drug coverage. You will continue to be a member of <plan name> that doesn't offer Medicare prescription drug coverage.

If you have Medicaid drug coverage, it won't pay for your prescription drugs.

Remember, even if you don't use a lot of prescription drugs now, you still should consider joining a Medicare prescription drug plan. As we age, most people need prescription drugs to stay healthy.

If you continue to qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you change your mind and would like to join, you can call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 30: Model Notice for Enrollment Status Update

(For use with Transaction Reply Codes (TRC) from User Interface (UI) changes)

Referenced in section: 60.7

[Member #]

Dear <Name of Member>:

Your enrollment in <Name of Plan> has been updated.

[*Insert one or more of the following, including sufficient detail to describe the specific enrollment change:*

- You have been enrolled in <name of plan>. Your coverage will start on <*insert start date*> and will end on <*insert end date*>. [*Insert information about premiums, if applicable, and how to access coverage, etc*.].

- Your enrollment in <*name of plan/old PBP*> has been changed to <name of plan/new PBP>. Your coverage in <*name of plan/new PBP*> will start on <*date*>. [*Insert information on premium differences (if any), cost sharing information, and other details the individual will need to ensure past and future coverage is clear*]

- Your enrollment in <*Name of Plan*> has been changed to start on an earlier date. Your coverage will start <*date*>. [*Include information about premiums, coverage, and how to get refunded for prescriptions purchased in the period of retroactive coverage.*]

- Your enrollment in <*Name of Plan*> has been changed to start on a later date. Your coverage with <*Name of Plan*> will start on < *date*>. [*Insert information about refunding premium, where applicable, and impact to paid claims*]

- Your enrollment in <*Name of Plan*> [*ended, will end*] on < *date*>. This means you [*don't, won't*] have coverage from <*Name of Plan*> after <*date*>. [*Insert appropriate descriptive information, such as premium owed if the date has moved forward, or premium refunds if the date has moved back, and impact on paid claims or how to submit claims, as applicable*]

- Your enrollment in <*Name of Plan*> has been cancelled. This means that you don't have coverage from <*Name of Plan*>. [*Insert information about refund of premium, if applicable, and 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*]

[*Insert if enrolling in a PFFS plan:* <Name of Plan>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before

each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[*Dual-eligible SNPs may omit the following paragraph*:]
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Call <*toll-free number*> <*days and hours of operation*> to get more information. TTY users should call <*toll-free TTY number*>.

Thank you.

Exhibit 31: Model Employer/Union Sponsored MA Plan Group Enrollment Mechanism Notice

Dear <name>

<Name of Employer/Union> is enrolling you in <plan name > as your retiree health benefit plan beginning <effective date>, unless you tell us by <insert date no less than 21 days from date of notice> that you don't want to join our plan. <Plan name> is a Medicare Advantage plan. This enrollment will automatically cancel your enrollment in a different Medicare Advantage plan or a Medicare Prescription Drug (Part D) plan. Please call us if you think you might be enrolled in a different Medicare Advantage plan or a Medicare Prescription Drug plan.

What do I need to know as a member of <plan name>?
This mailing includes important information about this plan and the coverage it offers, including a summary of benefits document. Please review this information carefully. If you want to be enrolled in this Medicare health plan, you don't have to do anything, and your enrollment will automatically begin on <effective date>.

Once you are a member of <Plan Name>, you have the right to appeal plan decisions about payment or services if you disagree. Read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when you get it to know which rules you must follow to get coverage with this Medicare Advantage Plan. Enrollment in this plan is generally for the entire year.

[***MA PFFS do not include the following paragraph:*** Beginning on the date <plan name> coverage begins, you must get all of your health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR SERVICES.]**

You will need to keep Medicare Parts A and B as <Plan Name> is a Medicare Advantage Plan. You can be in only one Medicare Advantage Plan at a time. It is your responsibility to inform <Plan Name> of any prescription drug coverage that you have or may get in the future.

By joining this Medicare health plan, you acknowledge that the Medicare health plan will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <plan name> will release your information [***MA-PD plans insert:*** including your prescription drug purchase history] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

What happens if I don't join <plan name>?
You aren't required to be enrolled in this plan. <insert information about other group sponsored plan options, if there are any>. You can also decide to join a different Medicare plan. Call 1-800-MEDICARE for help in learning how. However, if you decide not to be enrolled <insert consequences for opting out of group plan, like that you cannot return, or that other benefits are

impacted>. To request not to be enrolled by this process <insert clear instruction for opting out including telephone numbers and times of operation where those numbers will be answered>.

What if I want to leave <Plan Name>?
You may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Plan Name>.

<Plan Name> serves a specific service area. If you move out of the area that <Plan Name> serves, you need to notify the plan so you can disenroll and find a new plan in your new area.

[***MA-only plans insert the following, unless the employer/union provides other creditable coverage*:**
Remember that if you leave this plan and don't have creditable prescription drug coverage (as good as Medicare's prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

Thank you.

Attachment

Exhibit 32: Model Notice for Loss of Special Needs Status

Referenced in section: 50.2.5

Dear <Name of Member>:

<Insert plan or organization name> must disenroll a member from *<Insert plan name>* if a member doesn't *<describe special needs status>* and doesn't reestablish *<describe required special needs status>* prior to the expiration *<insert length of period of deemed continued eligibility >*.

Why am I receiving this notice?

Our records indicate that you no longer *<describe special needs status that individual has lost>*. To be a member of <plan name>, you must *<describe required special needs status>*.

How long will I continue to receive coverage?

<Plan name> will continue to cover your Medicare benefits until *<insert end date for period of deemed continued eligibility>*. You have *<insert length of period of deemed continued eligibility>* to re-qualify for our plan.

When will coverage end?

If, at the end of *<insert length of period of deemed continued eligibility>*, you haven't *<describe special needs criteria that must be met>* and you haven't enrolled in a different plan, we will disenroll you and you will be covered by Original Medicare beginning *<insert end date for period of deemed continued eligibility>*.

What do I do if my coverage ends?

When coverage from <plan name> ends, your Medicare prescription drug coverage ends too. To have new health care coverage and prescription drug coverage after <date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. For example, if you are returning to Original Medicare coverage, to get Medicare prescription drug coverage you must join a Medicare prescription drug plan. Please remember, if you disenroll from <plan name> and don't have or get other creditable prescription drug coverage (as good as Medicare prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

When can I join another plan?

Because you are no longer eligible for our plan, Medicare will give you a special one-time opportunity to change to a different Medicare Advantage Plan or Medicare Prescription Drug Plan. This opportunity begins now and ends when you enroll in a different plan or on *<insert date three months after the expiration of the period of deemed continued eligibility>*, whichever is earlier. If you don't take any action, <plan name> will continue to cover your Medicare benefits until *<insert end date for period of deemed continued eligibility>*.

Once you use the special one-time opportunity to change plans, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7,** anyone with Medicare can switch from one way of getting Medicare to another for the following year, including adding or dropping Medicare prescription drug coverage.
- **From January 1 through February 14,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period. If you join a Medicare Prescription drug plan, you will be automatically disenrolled from our plan and returned to Original Medicare.

Generally, you will be able to make changes only during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or qualify for extra help with prescription drug costs. If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*Dual-eligible SNPs may omit the following two paragraph*s:

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.]

What if I don't agree with this decision or if I have questions?

If this information is wrong and you continue to be eligible for <plan name> or if you believe you have already re-qualified for our plan and you want to stay a member of our plan, please contact us immediately at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 33: Model Notice for Loss of SNP Status - Notification of Involuntary Disenrollment

Referenced in section(s): 50.2.5

Dear <Name of Member>:

On <date> we sent you a letter that said you no longer *<describe special needs status that individual has lost>*. The letter said that if you didn't *<describe special needs criteria that must be met>*, we would disenroll you and you would be covered by Original Medicare beginning *<insert end date for period of deemed continued eligibility>*.

Why am I receiving this notice?
According to our records, you remain ineligible for <plan name>. Therefore, we asked Medicare to disenroll you from <plan name> beginning <date>.

What if I don't agree with this decision?

You have the right to ask us to reconsider this decision through the grievance process described in your [*insert* "Member Handbook" or "Evidence of Coverage", *as appropriate*].

What happens next?

Due to your disenrollment from <plan name>, you will be covered by Original Medicare, beginning <effective date> unless you take action.

When can I join another plan?

As described in our earlier letter, you have a special one-time opportunity to enroll in a different Medicare Advantage Plan or Medicare Prescription Drug Plan. This opportunity will end when you enroll in a different plan or on *<insert date three months after the expiration of the period of deemed continued eligibility>*, whichever is earlier.

Once you use the special one-time opportunity to change plans, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including adding or dropping Medicare prescription drug coverage.

- **From January 1 through February 14,** anyone enrolled in a Medicare Advantage Plan (except an MSA plan) has an opportunity to disenroll from that plan and return to Original Medicare. Anyone who disenrolls from a Medicare Advantage plan during this time can join a stand-alone Medicare Prescription Drug Plan during the same period.

Generally, you will be able to make changes only during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area, want to join a plan

in your area with a 5-star rating, or qualify for extra help with your prescription drug costs. If you qualify for extra help, you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[*Dual-eligible SNPs may omit the following two paragraphs*:]

What is extra help?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

Why is it important to find new drug coverage?

Please remember, if you don't enroll in another Medicare Advantage Plan with prescription drug coverage or a Medicare Prescription Drug Plan or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Information About Medigap Rights

You might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 34: MA Model Notice to Research Potential Out of Area Status

Referenced in section: 50.2.1.3

<Date>
<Member ID>

Dear <member name>:

We have recently received information that your address may have changed and that you may not live in the service area of <plan name>. **If you don't contact us to verify your address, you will be disenrolled from <plan name> effective <disenrollment effective date>.**

It is important that you contact us to verify your permanent address. You may use this form and return it to us in the enclosed envelope or you may call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Please note that your permanent address must be inside our service area in order for you to be a member of <plan name>. You may request that we send mail to you at another address outside of our service area. You may also temporarily reside for up to [*insert either* "six" *or the length of the plan's visitor traveler program (if any)*] months outside our service area and remain a member of <plan name>. But if you permanently move outside our service area or if you temporarily live outside our service area for more than six months in a row, we must disenroll you from <plan name>. You will have an opportunity to enroll in a plan that serves the area where you now live.

Your Permanent Address
Please tell us the permanent address where you live. Do not use a post office box.

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number:_____ _____

Your Temporary Address
If you are currently living somewhere other than your permanent address, please provide the address. Do not use a post office box. (You may skip this section if you are living at your permanent address.)

Street:_____
City, State, ZIP:_____
County:_____
Current Phone Number:_____
When did you begin living at this address?_____
When do you expect to return to your permanent address?_____

Your Mailing Address

If the address that you want us to use to send information to you is different than your permanent address, please provide it below. (You may skip this section if your mailing address is the same as your permanent address that you provided.)

Street or P.O. Box: _____
City, State, ZIP: _____
County: _____

If you have moved and have not notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

If you have any questions or need help, please call us at <customer service phone number>.

Thank you.

Exhibit 35: MA Model Notice for Disenrollment Due to Out of Area Status (No Response to Request for Address Verification)

Referenced in section: 50.2.1.3

<Date>
<Member ID>

Dear <member name>:

On <*date of notice requesting address verification*> we asked you to contact us so that we could determine whether you had moved out of the [*Optional:* Parent Organization Name] <plan name> service area. As we explained in our earlier letter, in order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to [*insert either* "six" *or the length of the plan's visitor traveler program (if any)*] consecutive months.

Our records show that you have not responded to our earlier letter. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.**

Beginning <effective date>, <plan name> won't cover any health care you get. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans add the following:* Beginning <effective date>, <plan name> also won't cover any prescriptions you get. You won't have any prescription drug coverage beginning <effective date> unless you have enrolled in another prescription drug plan.]

What if I disagree with this decision?
You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?
You may have up to two months to join a new Medicare Advantage Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

What if I don't enroll in a new plan right now?
If you don't enroll in a Medicare Advantage Plan during this special two-month period, you may have to wait to enroll in a new plan. Medicare limits when you can enroll in a new Medicare Advantage Plan. **From October 15 through December 7 each year**, you can enroll in a new Medicare Advantage Plan for the following year. You may not enroll in a new Plan during other times of the year unless you want to join a plan in your area with a 5-star rating or you meet certain special exceptions.

[*MA-PD plans insert the following four paragraphs*: **What happens to my Medicare Prescription Drug Coverage?**
When your coverage from <plan name> ends after <date>, your Medicare prescription drug coverage ends too. To have new prescription drug coverage after <date>, you need to join a new Medicare Advantage plan with Medicare prescription drug coverage or join a Medicare prescription drug plan.

Can I enroll in a new Medicare Prescription Drug Plan?
You may have up to two months to join a Medicare Prescription Drug Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area. If you don't enroll in a new plan during this special two-month period, you may have to wait to enroll in a new plan. **From October 15 – December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan for the following year. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What happens if I don't enroll in another Medicare Prescription Drug Plan?
Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

What if my premium was being deducted from my Social Security benefit check?
If your Medicare Part D premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[*Dual-eligible SNPs may omit the following two paragraphs*:]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What should I do if I've moved?
If you have moved and haven't notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?
If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 36: MA Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)

Referenced in section: 50.2.1.3

<Date>
<Member ID>

Dear <member name>:
Thank you for informing us of your recent change of permanent address. Your permanent address is now outside the <plan name> service area. In order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to [*insert either* "six" *or the length of the plan's visitor traveler program (if any)*] consecutive months. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.**

Beginning <effective date>, <plan name> won't cover any health care you receive. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

What if I disagree with this decision?
You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?
You may have up to two months to join a new Medicare Advantage Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

What if I don't enroll in a new plan right now?
If you don't enroll in a Medicare Advantage Plan during this special two-month period, you may have to wait to enroll in a new plan. Medicare limits when you can enroll in a new Medicare Advantage Plan. **From October 15 through December 7 each year**, you can enroll in a new Medicare Advantage Plan for the following year. You may not enroll in a new Plan during other times of the year unless you want to join a plan in your area with a 5-star rating or you meet certain special exceptions.

[*MA-PD plans insert*: **What happens to my Medicare Prescription Drug Coverage?**
When your coverage from <plan name> ends after <date>, your Medicare prescription drug coverage ends too. To have new prescription drug coverage after <date>, you need to join a new Medicare Advantage plan with Medicare prescription drug coverage or join a Medicare prescription drug plan.

Can I enroll in a new Medicare Prescription Drug Plan?
You may have up to two months to join a Medicare Prescription Drug Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about

plans that may serve your area. If you don't enroll in a new plan during this special two-month period, you may have to wait to enroll in a new plan. **From October 15 – December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan for the following year. If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What happens if I don't enroll in another Medicare Prescription Drug Plan?
Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*MA-PD plans insert:* **What if my premium was being deducted from my Social Security benefit check?**
If your Medicare Part D premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE.]

[*Dual-eligible SNPs may omit the following two paragraphs*:]
Can I get help paying my premiums and other out-of-pocket costs?
People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

What should I do if I've moved?
If you have moved and haven't notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?
If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.