Medicare Prescription Drug Benefit Manual

Chapter 3 - Eligibility, Enrollment and Disenrollment

Updated: August 19, 2011
(Revised: November 16, 2011, August 7, 2012, August 30, 2013, August 30, 2014, July 6, 2015, September 1, 2015, September 14, 2015, December 30, 2015 *& May 27, 2016*)

This guidance update is effective for contract year 2016. All enrollments with an effective date on or after January 1, 2016, 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.

The revisions made on *May 27, 2016*, *which are specific to good cause reinstatement policy,* are effective for contract year *2017*. All enrollments with an effective date on or after January 1, *2017*, must be processed in accordance with the*se* revision*s* as appropriate. Organizations may, at their option, implement any of these changes, including *the* new model notice, 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.

Table of Contents

10 – Definitions 7
20 - Eligibility and Enrollment in a Part D Plan 13
20.1 - Entitlement to Medicare Parts A and/or B 14
20.2 - Place of Permanent Residence 14
20.2.1 – U.S. Citizenship or Lawful Presence 15
20.3 - Completion of Enrollment Request 15
20.4 – Other Coverage through an Employer/Union Group 16
20.5 – Passive Enrollment by CMS 17
30 – Enrollment and Disenrollment Periods and Effective Dates 18
30.1 – Initial Enrollment Period for Part D (IEP for Part D) 19
30.2 – Annual Election Period (AEP) 20

30.3 - Special Enrollment Period (SEP) 20
30.3.1 - SEPs for Changes in Residence 23
30.3.2 – SEP for Dual-eligible Individuals or Individuals Who Lose Their Dual-eligibility 24
30.3.3 - SEPs for Contract Violation 25
30.3.4 - SEPs for Non-renewals or Terminations 26
30.3.5 - SEP for Involuntary Loss of Creditable Prescription Drug Coverage 28
30.3.6 - SEP for Individuals Not Adequately Informed about Creditable Prescription Drug Coverage 28
30.3.7 - SEP for Enrollment/Non-enrollment in Part D due to an Error by a Federal Employee 28
30.3.8 - SEPs for Exceptional Conditions 28
30.4 - Effective Date of Enrollment 35
30.5 - Effective Date of Voluntary Disenrollment 38
40 - Enrollment Procedures 40
40.1 - Format of Enrollment Requests 41
40.1.1 - Paper Enrollment Forms 42
40.1.2 - Electronic Enrollment 42
40.1.3 - Enrollment via Telephone 44
40.1.4 - Auto- and Facilitated Enrollment 45
40.1.5 - Re-Assignment of Certain LIS Beneficiaries 55
40.1.6 - Group Enrollment Mechanism for Employer/Union Sponsored PDPs 60
40.1.7 - Enrollment for Beneficiaries in Qualified State Pharmaceutical Assistance Programs (SPAPs) 62
40.2 - Processing the Enrollment Request 62
40.2.1 - Who May Complete an Enrollment Request 67
40.2.2 - When the Enrollment Request Is Incomplete 68
40.2.3 - PDP Sponsor Denial of Enrollment 70
40.3 - Transmission of Enrollments to CMS 71
40.4 - Information Provided to Member 71
40.4.1 - Prior to the Effective Date of Enrollment 72
40.4.2 - After the Effective Date of Coverage 73
40.5 - Enrollments Not Legally Valid 74
50 - Disenrollment Procedures 76
50.1 - Voluntary Disenrollment by an Individual 76
50.1.1 – Requests Submitted via Internet 77
50.1.2 – Request Signature and Date 77
50.1.3 – Effective Date of Disenrollment 78
50.1.4 – PDP Sponsor Denial of Voluntary Disenrollment Request 78

50.1.5 – Notice Requirements 78
50.2 - Required Involuntary Disenrollment 79
50.2.1 - Sponsor Receives Notification of Possible Residence Change 80
50.2.1.1 – General Rule 81
50.2.1.2 – Effective Date of Disenrollment 81
50.2.1.3 - Researching and Acting on a Change of Address 82
50.2.1.4 – Special Procedures for Auto and Facilitated Enrollees Whose Address Is Outside the PDP Region 83
50.2.1.5 - Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable 83
50.2.1.6 – Notice Requirements 84
50.2.2 – Loss of Eligibility for Part D 85
50.2.3 - Death 85
50.2.4 - Terminations/Nonrenewals 85
50.2.5 - Material Misrepresentation Regarding Third-Party Reimbursement 86
50.2.6 – Failure to Pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) 86
50.2.7 – Unlawful Presence Status 87
50.3 - Optional Involuntary Disenrollments 87
50.3.1 - Failure to Pay Premiums 88
50.3.2 - Disruptive Behavior 93
50.3.3 - Fraud and Abuse 96
50.4 - Processing Disenrollments 97
50.4.1 - Voluntary Disenrollments 97
50.4.2 - When the Disenrollment Request is Incomplete 98
50.4.3 - Involuntary Disenrollments 98
50.5 - Disenrollments Not Legally Valid 99
50.6 - Disenrollment Procedures for Employer /Union Sponsored Coverage Terminations 99
50.6.1 – Group Disenrollment for Employer/Union Sponsored PDPs 101
60 - Post-Enrollment Activities 102
60.1 - Cancellations 102
60.1.1 - Cancellation of Enrollment 102
60.1.2 - Cancellation of Disenrollment 103
60.1.3 – When A Cancellation Transaction is Rejected by CMS Systems (TRC 284) 104
60.1.4 – Cancellation Due to Notification from CMS (TRC 015) 104
60.2 - Reinstatements 104
60.2.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator, Erroneous Loss of Part D Eligibility Indicator, Erroneous Incarceration Information, or Erroneous Unlawful Presence Information 105

60.2.2 - Reinstatements Based on Beneficiary Cancellation of New Enrollment 107
60.2.3 - Reinstatements Due to Mistaken Disenrollment Due to Plan Error 107
60.2.4 - Reinstatements Based on a Determination of Good Cause for Failure to Pay Plan Premiums or Part D-IRMAA Timely 108
60.2.4.1 - Process for Good Cause Determinations for Nonpayment of Plan Premiums .. 110
60.2.4.2 – Process for Good Cause Determinations for Nonpayment of Part D-IRMAA. 113
60.3 - Retroactive Enrollments 114
60.4 - Retroactive Disenrollments 115
60.5 - Retroactive Transactions for Employer/Union Group Health Plan (EGHP) Members. 116
60.5.1 - EGHP Retroactive Enrollments 117
60.5.2 - EGHP Retroactive Disenrollments 117
60.6 – Multiple Transactions 118
60.7 - User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries 119
60.8 - Storage of Enrollment and Disenrollment Request Records 121
APPENDICES 122
Appendix 1: Summary of Notice Requirements 123
Appendix 2: Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests 128
Appendix 3: Setting the Application Date on CMS Enrollment Transactions 130
Appendix 4: Examples of Good Cause Determinations 131
EXHIBITS 136
Exhibit 1 - PDP Model Enrollment Form 137
Exhibit 1a – Information to Include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period 142
Exhibit 1c: Model Plan Selection Form for Switch from Plan to Plan within Parent Organization 147
Exhibit 2 - PDP Model Notice to Acknowledge Receipt of Completed Enrollment 150
Exhibit 2a - Model Notice to Acknowledge Receipt of Completed Enrollment Request for another Plan in the Same Parent Organization 153
Exhibit 2b - PDP Model Notice to Acknowledge Receipt of Completed Enrollment and to Confirm Enrollment 155
Exhibit 3 - Model Notice to Request Information 158
Exhibit 4 - PDP Model Notice to Confirm Enrollment 159
Exhibit 5 - PDP Model Notice to Individuals Identified on CMS Records As Members of Employer/Union Group Receiving Employer Subsidy 162
Exhibit 6 - PDP Model Notice for Denial of Enrollment 163
Exhibit 7 – PDP Model Notice for CMS Rejection of Enrollment 165
Exhibit 8 - PDP Model Notice to Send Out Disenrollment Form 167
Exhibit 9 - PDP Model Disenrollment Form 169

Exhibit 9a: Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period 170
Exhibit 10 - PDP Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member 171
Exhibit 10a - PDP Notice to Confirm Voluntary Disenrollment Identified Through TRR 173
Exhibit 10b – PDP Notice to Confirm Disenrollment Identified Through Transaction Reply Report – Reassigned LIS 175
Exhibit 10c: Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan 176
Exhibit 11a: Model Notice to Request Information (Disenrollment) 178
Exhibit 12 - PDP Model Notice for CMS Rejection of Disenrollment 179
Exhibit 13 - PDP Model Notice of Disenrollment Due to Death 180
Exhibit 13a - PDP Model Notice for auto-enrollments provided by CMS with recent deceased code 181
Exhibit 14 - PDP Model Notice of Disenrollment Due to Loss of Part D Eligibility 182
Exhibit 15 - PDP Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status 183
Exhibit 16 - PDP Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Termination 184
Exhibit 17 - Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error 185
Exhibit 18 - PDP Model Notice to Close Out Request for Reinstatement 186
Exhibit 19 - PDP Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment 187
Exhibit 20 - PDP Notice of Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment 188
Exhibit 21 - PDP Notice of Failure to Pay Plan Premium - Confirmation of Involuntary Disenrollment 190
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 192
Exhibit 21b: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Plan Premium Amount Due for Reinstatement 194
Exhibit 21c: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Plan Premium Amount Due for Reinstatement 196
Exhibit 21d: Model Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums 198
Exhibit 21e: Model Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment 200
Exhibit 21f: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement) 202

Exhibit 22a - Model Confirmation of Reinstatement 204
Exhibit 23 - Model Acknowledgement of Request to Cancel Disenrollment Letter 205
Exhibit 24 - PDP Model Notice to Confirm Auto-Enrollment 206
Exhibit 25 - PDP Model Notice to Confirm Facilitated Enrollment 208
Exhibit 25b: Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015) 210
Exhibit 26 - PDP Acknowledgement of Request to Decline or Opt-Out of Part D Prior to Effective Date 211
Exhibit 26a - PDP Acknowledgement of Request to Disenroll from PDP and Opt-Out of Part D After Effective Date 212
Exhibit 27 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region 213
Exhibit 28 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor DOES NOT offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region 214
Exhibit 29 - Model Reassignment Confirmation 215
Exhibit 30 - Optional Notice for “Losing Plan” to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC) 216
Exhibit 31 - Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes 217
Exhibit 32 - Model Employer/Union Sponsored Prescription Drug Plan Group Enrollment Mechanism Notice 218
Exhibit 33: PDP Model Notice to Research Potential Out of Area Status 220
Exhibit 34: PDP Model Notice for Disenrollment Due Out of Area Status (No Response to Request for Address Verification) 222
Exhibit 35 – PDP Notice of Disenrollment Due to Out of Area Status (Upon New Address Verification from Member) 224
Exhibit 36: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration 226

Instructions provided in this guidance apply to Medicare Prescription Drug Plans (PDPs) and to 1876 Cost plans offering an optional supplemental Part D benefit. Guidance for eligibility, enrollment and disenrollment procedures for Medicare Advantage (MA) plans is established in the MA Enrollment and Disenrollment Guidance (Chapter 2 of the Medicare Managed Care Manual).

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 sponsor as defined below. Sponsors 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 sponsor (postmark is irrelevant).
- For requests received by fax, the application date is the date the fax is received on the sponsor'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 sponsor receives the enrollment request from the agent/broker. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the sponsor, 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 a sponsor ultimately retrieves or downloads the request.
- For electronic enrollment requests, the application date is the date the applicant completes the request through the sponsor's electronic enrollment process. This is true regardless of when a sponsor 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 sponsor receives the request. For example, if a valid group enrollment mechanism file is received by the sponsor 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.

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.

Auto–Enrollment – The process by which full benefit dual eligible individuals are enrolled into a Part D Plan by CMS (§40.1.4 (A) (1)). See definition of Full Benefit Dual Eligible Individual.

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 sponsor before the enrollment effective date. When an enrollment request has been appropriately cancelled, the election period used to make the request remains available for use within the appropriate time frame.

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 or enrollment in Medicare Part B is obtained by the sponsor (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).

Denial of Enrollment Request - Occurs when a sponsor 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 resides outside of the plan's service area, 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 a Prescription Drug plan begins. The PDP sponsor must determine the effective date of enrollment for all enrollment requests. Instructions for determining the correct effective date of coverage can be found in §30.4.

Election - Enrollment in, or voluntary disenrollment from, a Part D 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 a Part D plan. The type of election period determines the effective date of the Part D coverage. 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 a Part D plan. Several model individual enrollment forms are provided in the Exhibits at the end of this guidance. An individual who is a member of a Part D plan and who wishes to elect another Part D plan, even if it is offered by the same parent organization, must complete a new election during a valid enrollment period to enroll in the new Part D plan**.** However, that individual may use a short enrollment form to make the election in place of the comprehensive individual enrollment form, or, may complete the election via an electronic enrollment mechanism, as described in §40.1.2 of this guidance, or by telephone, as described in §40.1.3 of this guidance, if the sponsor offers these options. In addition, sponsors may want to collaborate with Employer or Union Group Health Plans (EGHPs) to use a single enrollment form (or other CMS approved method, if available) for EGHP members. Beneficiaries or their legal representatives must complete an enrollment request mechanism (e.g. enrollment form) to enroll in a Part D plan.

Evidence of Entitlement (Medicare Part A or Part B Coverage) - For the purposes of completing an enrollment request, the sponsor must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen) or its equivalent. Therefore, the applicant is not required to provide evidence of entitlement to Medicare Part A or enrollment in Part B with the enrollment request. If CMS systems do not show Medicare entitlement, the sponsor 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 sponsor must consider an SSA award letter that shows the Medicare HICN and effective date of Part A/B as evidence of Medicare entitlement (see §§20.1 & 40.2, subsection B).

Facilitated Enrollment – The process by which other LIS beneficiaries who are eligible for the low income subsidy are enrolled in a Part D plan. "Other LIS" eligible individuals are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e. eligible only for Medicaid payment of Medicare premium 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 or State Medicaid Agency and are determined eligible for LIS (see §40.1.4 (A) (2)).

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 § 60.2.4 under which an individual may be reinstated into his/her Part D 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 in the custody of a penal authority and confined to a correctional facility, such as a jail or prison, or a mental health institution as a result of a criminal offense. Such individuals reside outside of the service area for the purposes of Part D plan eligibility, even if the correctional facility is located within the plan's service area. Individuals who are confined to Institutions for Mental Disease (IMDs), such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, as a result of violations of the penal code, are incarcerated as CMS defines the term for the purpose of Part D plan eligibility. The place of residence for these confined individuals is therefore excluded from the service area of a Part D plan on that basis.

Individuals who are confined to IMDs, such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, for other reasons (e.g., because of court orders unrelated to penal violations) are not incarcerated. Normal service area rules apply to these individuals.

Institutionalized Individual - An individual who resides in a facility as described in §30.3.8, subsection 5.

Involuntary Disenrollment – Disenrollment made necessary due to the sponsor's determination that the individual is no longer eligible to remain enrolled in a Part D plan, or when the sponsor otherwise initiates disenrollment (e.g. failure to pay plan premiums, plan termination). Procedures regarding involuntary disenrollment are found in §§50.2, 50.3, & 50.4.3.

Late Enrollment Penalty - An amount added to the Part D 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.

Lawfully Present Individual – Refer to 8 CFR 1.3 (Lawfully present aliens for purposes of applying for Social Security benefits) for a definition of an alien who is considered lawfully present in the United States. An individual who is not lawfully present in the Unites States is not eligible for any federal public benefit, including payment of Medicare benefits. (8 U.S.C. 1611)

MA–PD plan – A Medicare Advantage plan (PBP) that provides Medicare prescription drug coverage.

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.

Passive Enrollment – 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 Part D plan by taking no action. CMS will determine when passive enrollment is appropriate and will initiate contact through the Part D sponsor's CMS account manager in order to inform a sponsor if they are eligible to enact passive enrollment (§20.5).

PDP sponsor – Refer to Chapter 1 (General Provisions) for a definition of PDP sponsor, Part D sponsor, or Part D plan.

Plan Performance Rating – A CMS-assigned rating, measured in stars from one to five, indicates a sponsor'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 Rating (or "overall rating") is publicly available on Medicare.gov. CMS assigns the rating in October for the following year based on the sponsor's most recent quality and performance data.

Receipt of Enrollment Request – Part D plan sponsors may receive enrollment requests through various means, as described in §40.1. The sponsor 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 - An action that may be taken by CMS to correct an erroneous disenrollment from a Part D plan. The reinstatement corrects an individual's records by canceling a disenrollment or cancellation of enrollment to reflect no gap in enrollment in a Part D plan.
A reinstatement may result in retroactive disenrollment from another Part D plan or Medicare managed care plan.

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

Service Area – For a stand-alone Medicare prescription drug plan, the service area is the CMS-approved geographic area from which the plan sponsor is permitted to accept enrollment requests.

System Error - A "system error" is defined for the purposes of this guidance as an unintended error or delay in enrollment request processing that is clearly attributable to a system such as Social Security Administration (SSA) systems, Railroad Retirement Board (RRB) systems, or CMS systems, and is related to Medicare entitlement information or other information required to process a Part D enrollment request.

Voluntary Disenrollment – Disenrollment initiated by a member or his/her authorized representative (§§30.5, 50.1).

20 - Eligibility and Enrollment in a Part D Plan

42 CFR 423.30

In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if:

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

2. The individual has current Part D eligibility in CMS systems; and

3. The individual permanently resides in the service area of a PDP.

4. The individual is a U.S. citizen or lawfully present in the United States (see exceptions in §20.2.1 for persons unlawfully present at the time of the enrollment request);

An individual who is living abroad or is incarcerated is not eligible for Part D as he or she cannot meet the requirement of permanently residing in the service area of a Part D plan.

A PDP sponsor may not impose any additional eligibility requirements as a condition of enrollment other than those permitted by CMS.

Individuals may request enrollment in a Part D plan only during an enrollment period, as described in §30. A PDP sponsor cannot deny a valid enrollment request from any Part D eligible individual residing in its service area, except as provided in this guidance. Individuals enrolling in a Medicare Advantage Prescription Drug (MA-PD) plan are subject to the procedures provided in the MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2).

Individuals in a cost-based HMO/CMP have the option to enroll in a standalone PDP, regardless of whether Part D is offered as an optional supplemental benefit by the cost plan. Individuals enrolling in a Part D plan that is offered as an optional supplemental benefit in a Cost-based HMO/CMP plan must do so according to the requirements for enrollment in a PDP contained in this guidance. Such an individual must be a cost plan member to enroll in the cost plan's optional supplemental Part D benefit.

A PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. However, if an individual enrolls in a PDP and continues to enroll in an employer/union plan for which the retiree drug subsidy (RDS) is claimed, the retiree drug subsidy will terminate, at which point coordination of benefits (COB) rules will apply.

A Part D eligible individual may not be enrolled in more than one Part D plan at the same time. A Part D eligible individual may not be simultaneously enrolled in a PDP and a Medicare Advantage (MA) plan except for a MA Private Fee-For-Service (PFFS) plan that does not offer the Part D benefit, a Medicare Medical Savings Account (MSA), or unless otherwise provided under CMS waiver authority.

The PFFS exception is applied at the plan level (i.e. the PBP or "plan benefit package" level). An individual enrolled in an MA PFFS plan that does not offer Part D may enroll in a stand-alone PDP, even if the same MA organization offers other plans (including PFFS plans) that include a prescription drug benefit.

20.1 - Entitlement to Medicare Parts A and/or B

To be eligible for Part D and to enroll in a PDP, an individual must be entitled to Medicare Part A or enrolled in Part B as of the effective date of coverage under the PDP. Section 40.2 provides information on verification of Medicare entitlement.

20.2 - Place of Permanent Residence

An individual is eligible for Part D and able to enroll in a PDP if he or she permanently resides in the service area (region) of the PDP. A temporary stay in the PDP's service area does not enable the individual to enroll in the Part D plan; the PDP sponsor must deny such an enrollment request.

An individual who is living abroad or is incarcerated does not meet the requirement of permanently residing in the service area of a Part D plan, even if the correctional facility, institution or other place of confinement is located within the plan service area (see §10 for definition of "incarceration"). Individuals who are confined in state hospitals, IMDs (Institutions for Mental Disease), psychiatric hospitals, or the psychiatric unit of a hospital, as a result of court orders not related to penal violations, are not incarcerated as CMS defines that term, and are therefore not excluded on that basis from the service area of a Part D plan. Thus, they are eligible for Part D, provided that they meet the other Part D eligibility requirements.

A permanent residence is normally the primary residence of an individual. Generally, permanent residence is established by the address provided by the individual, but a PDP sponsor may request additional information, such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, or utility bills if there is a question. 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 or her place of residence on the enrollment request, the PDP sponsor must contact the individual to confirm that the individual lives in the service area. If there is a dispute over where the individual permanently resides, the PDP sponsor should determine whether, according to the law of the State, the person would be considered a resident of that State. Additional instructions regarding disenrollment of members who may live out of the sponsor's service can be found in §50.2.1 of this guidance.

Separately, individuals may have 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 for example, PDP sponsors should make every effort to accommodate these requests, and should use this address to provide the required notices in this guidance and other plan mailings as appropriate. The model PDP enrollment forms provided in this guidance include a mechanism to collect an alternate mailing address. Use of an alternate mailing address does not eliminate or change the residency requirement for the purposes of PDP eligibility.

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.

Additional information regarding residence for individuals that are auto enrolled or facilitated enrolled is provided in §50.2.1 of this guidance.

20.2.1 – U.S. Citizenship or Lawful Presence

An individual is eligible to elect enrollment in a Part D plan if he or she is a U.S. citizen or lawfully present in the United States. CMS will notify the PDP sponsor if the individual is not eligible to enroll on this basis at the time of enrollment. The PDP sponsor must deny an enrollment request from an individual who does not meet this requirement.

> EXCEPTION: *In the case where CMS systems show that an individual will have lawful presence status on or before the enrollment effective date, the sponsor must accept and process the enrollment request. A PDP sponsor must not deny an enrollment request on the basis that the applicant is not lawfully present at the time the request is received if CMS systems indicate that he or she will be lawfully present in the United States as of the enrollment effective date.*

If an individual provides evidence of their lawful presence status to the PDP sponsor, the sponsor may not consider it when determining eligibility for enrollment. The sponsor may not request from an applicant any documentation of U.S. citizenship or alien status. CMS will provide the official status to the PDP sponsor at the time of enrollment. If there is a dispute over the lawful presence status of an individual, the PDP sponsor should refer the individual to the Social Security Administration to have their status reviewed and adjusted, if necessary.

20.3 - Completion of Enrollment Request

Unless otherwise specified by CMS, an eligible individual enrolls in a PDP by completing and submitting an enrollment request to the PDP organization, providing all of the required information to complete enrollment within required time frames. Furthermore, transferring from one PBP to another within the same organization is still an enrollment request and must be handled as any other enrollment request. An individual who switches from one benefit package to another with the same PDP sponsor must complete an enrollment request within the required time frames. Such individuals may use a short enrollment form to request enrollment in the new plan offered by the same parent organization. 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 (S#) and legal entities that are owned and operated by a single organization. Enrollment request formats include paper enrollment forms and other mechanisms approved by CMS and offered by the PDP organization. The model enrollment form is provided in Exhibit 1. The model short enrollment form is provided in Exhibit 1b.

Except as permitted by CMS for individuals enrolling in a PDP by other means, a PDP sponsor must deny enrollment to any individual who does not properly complete an enrollment request within required time frames. Procedures for completing enrollment requests are provided in §40.2.

20.4 – Other Coverage through an Employer/Union Group

CMS systems will compare Part D enrollment transactions to information regarding the existence of employer or union 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 with a transaction reply code (TRC) 127 (see CMS' Plan Communications User Guide for information on TRCs).

Within 10 calendar days of receipt of the Code 127 conditional rejection, the PDP sponsor must contact the individual by phone or letter to confirm the individual's intent to enroll in Part D (see Exhibit 5), and that the individual understands the implications of enrollment in a Part D plan on his or her employer/union coverage. The individual will have 30 calendar days from the date he or she is contacted or notified to respond. The PDP sponsor may contact the individual in writing (see Exhibit 5) 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/union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the PDP sponsor 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 on the receipt of the beneficiary's initial enrollment request, not when the individual confirms that s/he wants to enroll. This effective date may be retroactive in the event that the confirmation step occurs after the effective date. In these cases, sponsors may utilize the Code 61 enrollment transaction code to submit the enrollment transaction directly to CMS as provided in the Plan Communications User Guide (PCUG).

PDP sponsors are 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 6).

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

PDP sponsors 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.

Further information about employer/union sponsored group health plans can be found in Chapter 12 of this manual.

20.5 – Passive Enrollment by CMS

Under Medicare laws and regulations, Medicare beneficiaries must make an enrollment request to enroll in a Part D 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 a Part D plan under a passive enrollment request process in specific, limited circumstances generally associated with either immediate plan terminations or in other situation where 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 Part D plan by taking no action. CMS will determine when passive enrollment is appropriate and will initiate contact through the Part D sponsor's CMS account manager. CMS will provide specific instructions directly to the affected sponsor(s), 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. 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 premium not significantly higher
- New plan's Part D benefit and formulary structure would be equivalent to or of higher value than current plan

30 – Enrollment and Disenrollment Periods and Effective Dates

42 CFR 423.38

In order for a PDP sponsor 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 PDP sponsor to determine the enrollment period of each enrollment or disenrollment request. To make this determination, the plan sponsor 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 and Exhibit 9a for optional use with disenrollment 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 3 & 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: A plan sponsor'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 3 periods in which an individual may enroll in and/or disenroll from a PDP:

- The Initial Enrollment Period for Part D (IEP for Part D);
- The Annual Election Period (AEP);
- All Special Enrollment Periods (SEP).

During the AEP, individuals may enroll in and disenroll from a PDP plan, or choose another PDP plan. Depending on the SEP, an individual may be limited to enrolling in or disenrolling from a PDP plan. Individuals may enroll in a PDP during the IEP for Part D. Each individual has one election per enrollment period; once an enrollment or disenrollment becomes effective, the election has been used.

Unless a CMS-issued enrollment sanction or a CMS-approved capacity limit applies, all PDP sponsors must accept enrollments into their PDP plans during the AEP, an IEP for Part D, and an SEP. PDP enrollment periods coordinate with similar periods in Medicare Advantage (MA) to accommodate enrollment in MA plans with a Part D benefit (MA-PD plans).

The last enrollment or disenrollment choice made during an enrollment period, determined by the date a request was received by the PDP sponsor, will be the choice that becomes effective. As outlined in CMS' systems guidance for PDP sponsors (and MA organizations), the enrollment transaction will include this information (the "application date").

30.1 – Initial Enrollment Period for Part D (IEP for Part D)

The initial enrollment period 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 an individual is entitled to Part A OR enrolled in Part B, AND lives in the service area of a Part D plan.

At the beginning of the Part D program, there was an IEP for Part D for all current Medicare beneficiaries and individuals who became eligible for Medicare in January 2006 that began on November 15, 2005 and ended May 15, 2006.

Individuals who are becoming eligible for Medicare will have an Initial Enrollment Period for Part D that is the 7 month period surrounding Medicare eligibility (same as the IEP for Part B). The IEP for Part B is the 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.

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

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.

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 PDP sponsor receives a completed enrollment request.

Ultimately, CMS provides a Part D eligibility effective date and maintains it in CMS systems.

EXAMPLE 1 -- IEP for Part D surrounding 65th birthday:
Mrs. Smith's 65th birthday is April 20, 2010. She is eligible for Medicare Part A and her Part B initial enrollment period begins on January 1, 2010. Therefore, her IEP for Part D begins on January 1, 2010, and ends on July 31, 2010.

EXAMPLE 2 -- IEP for working individual:

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.

EXAMPLE 3 -- IEP exception for Part D:

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 lives in a plan service area. His IEP for Part D is March 2010 – September 2010.

EXAMPLE 4 -- IEP for retroactive Medicare determination:

Mr. Schlosser received notification of his Medicare determination on June 15, 2010. He was informed in this notice that Medicare Part A will be effective as of July 1, 2009. Therefore, his Part D initial enrollment period begins in June 2010 and ends September 30, 2010.

Once an individual uses his/her IEP for Part D enrollment and this enrollment becomes effective, this enrollment period ends. Refer to the table in §30.4 of this guidance for effective date information.

30.2 – Annual Election Period (AEP)

Beginning in 2011, the AEP is from October 15 through December 7 of every year. It 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. Plan sponsors may use these descriptions of the AEP in their member materials as well as in materials for prospective members.

There is one AEP enrollment/disenrollment choice available for use during this period. An enrollment/disenrollment election cannot be changed after the end of the AEP.

Refer to §§30.4 and 30.5 for effective date information.

30.3 - Special Enrollment Period (SEP)

Special enrollment periods constitute periods outside of the usual IEP for Part D or AEP 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 eligible individuals, for individuals whose current plan terminates, for individuals who change residence and for individuals who meet "exceptional

conditions" as CMS may provide, consistent with §1860D-1(b) of the Act and §423.38(c) of the Part D regulations.

Depending on the nature of the particular special election period, an individual may take a variety of actions, including:

- Discontinuing enrollment in an MA plan and enrolling in Original Medicare with a new Part D plan
- Joining a Part D plan for the first time
- Switching from one Part D plan to another Part D plan

Certain SEPs may be limited to an enrollment or disenrollment request. If the individual disenrolls from (or is disenrolled from) the PDP, the individual may subsequently enroll in a new Part D plan within the SEP time period. Once the individual's enrollment in a new Part D plan becomes effective, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the SEP ends when the individual's enrollment in a new Part D plan becomes effective or when the SEP time frame ends, whichever comes first, unless specified otherwise for an SEP.**

Note: An individual's eligibility for an SEP does not convey eligibility to enroll in the plan; in addition to having a valid enrollment period an individual must also meet all applicable Part D eligibility criteria.

It is generally the responsibility of the PDP sponsor to determine whether the individual is eligible for the SEP. The exception to this determination requirement would be enrollment and disenrollment requests completed by or approved by CMS. 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 9a 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 otherwise required in this guidance, the organization MUST accept verbal or written confirmation from the individual regarding the conditions that make him or her eligible for the SEP. 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 electronic enrollment mechanism or the Medicare OEC (without accompanying CMS approval), the sponsor 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 sponsor must document this contact and retain this with the enrollment record. If the sponsor obtains this confirmation through a written notice, such notice must include the option (and information) needed to call the sponsor and confirm this information verbally. If the sponsor is not able to obtain this confirmation before

the end of the required timeframe for processing an enrollment request, the sponsor must deny the enrollment or disenrollment request and provide the individual a denial notice (see Exhibit 6).

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	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 want to obtain VA benefits?
Dual Eligible	Do you currently have Medicaid coverage? Does your state pay for your Medicare premiums? Did you recently receive a yellow letter from Medicare (for full duals)? Have you recently lost coverage under Medicaid?
Other Low Income Subsidy	Do you receive extra help? Have you recently received a green letter from Medicare? Did you receive a letter from Medicare letting you know that you automatically qualify for extra help? Do you receive SSI cash benefits without Medicaid? How much do you pay for your prescriptions?
Institutionalized	Are you moving into or are you a current resident of an institution, such as a nursing facility or long-term care hospital? Are you moving out of such a facility?
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 the actual enrollment or disenrollment. For example, if an SEP exists for an individual from May through July, then a PDP sponsor must receive an enrollment or disenrollment request from that individual sometime between May 1 and July 31 in order to consider the request to have

been made during the SEP. However, the type of SEP will dictate the effective date of coverage, and that effective date of coverage can occur after July 31. The following discussion of SEPs and their corresponding effective dates will demonstrate this concept more fully.

30.3.1 - SEPs for Changes in Residence

An SEP for changes in residence exists for these scenarios:

1. individuals who are no longer eligible to be enrolled in a PDP due to a change in permanent residence outside of the PDP's service area;
2. individuals who were not eligible for Part D because they have been out of the U.S. and have now moved back to the U.S.;
3. individuals who were not eligible for Part D because they were incarcerated and have now been released;
4. individuals who will have new Medicare health or Part D plans available to them as 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 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 two months following the month of the move, whichever is later.

If the plan learns from CMS or U.S. Post Office (as described in §50.2.1) that the individual has been out of the service area for over twelve months and the plan has not been able to confirm otherwise with the individual, the SEP will begin at the beginning of the twelfth month and continues through to the end of the fourteenth month.

The effective date of the enrollment is determined by the date the PDP sponsor receives the enrollment request. The individual may choose an effective date of up to three months after the month in which the PDP sponsor 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 PDP sponsor receives the completed enrollment request.

EXAMPLE 1:
A beneficiary is a member of a PDP in Florida and intends to move to Arizona on June 18. An SEP exists for this beneficiary from May 1 through August 31.

A. If a PDP sponsor in Arizona receives a completed enrollment form from the beneficiary in May and since the individual is not moving to the new service area until June 18th, the beneficiary can choose an effective date of July 1, August 1, or September 1.

B. If the PDP sponsor receives the completed enrollment form 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 PDP sponsor receives the completed enrollment form in July, the beneficiary can 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 a PDP. 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 enrolls in a PDP, the individual must provide the specific address where s/he will permanently reside upon moving into the service area, so that the PDP sponsor can determine that the individual meets the residency requirements for enrollment in the plan.

Disenrollment from Previous PDP

Please keep in mind that a member of a PDP who moves permanently out of the service area must be involuntarily disenrolled from the plan. A member of a PDP who resides out of the service area for over twelve months must be involuntarily disenrolled from the plan. CMS has established an SEP that allows an individual adequate time to choose a new PDP, given the fact that the individual will no longer be enrolled in the original PDP after the month of the move or after the twelfth month (whichever is appropriate). Unless an individual elects new coverage during a valid enrollment period, he/she will be enrolled in Original Medicare without Medicare prescription drug coverage. If the individual does not elect new prescription drug coverage for an effective date immediately after the termination of the old coverage, he/she may be subject to a Part D late enrollment penalty (LEP). See Chapter 4 of the Medicare Prescription Drug Manual for more information.

30.3.2 – 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/or Part B and receive any type of assistance from the Title XIX (Medicaid) program. This also includes individuals often referred to as “partial duals” who receive cost sharing assistance under Medicaid (e.g. QMB, SLMB, 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, a Part D plan. The effective date of the individual’s enrollment in their new plan would be the first of the month following receipt of an enrollment request. However, as described in 40.1.4, the effective date for auto-enrollments may be retroactive.

In addition, PDP eligible individuals no longer eligible for benefits under Title XIX benefits will have an SEP beginning with the month they receive notice of the loss of eligibility plus two additional months to make an enrollment choice in another PDP, an MA-PD, or to disenroll entirely from Part D.

30.3.3 - SEPs for Contract Violation

In the event an individual is able to demonstrate to CMS that the PDP of which he/she is a member substantially violated a material provision of its contract under Part D, the individual may disenroll from the PDP and enroll in another Part D plan. Substantial violations in relation to the individual include, but are not limited to:

- failure to provide the individual on a timely basis benefits available under the plan;
- failure to provide benefits in accordance with applicable quality standards; or
- the PDP sponsor (or its agent) materially misrepresented the PDP when marketing the PDP.

The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately enrolls in a new Part D plan upon disenrollment from the original PDP.

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, an SEP exists such that an individual may elect another Part D plan during the last month of enrollment in the PDP sponsor, for an effective date of the month after the month the new PDP sponsor receives the completed enrollment request.

> **EXAMPLE**
> On January 16, CMS determines, based on a member's allegations, that the PDP sponsor substantially violated a material provision of its contract. As a result, the member will be disenrolled from the PDP on January 31. An SEP exists for this beneficiary beginning January 16 and lasting until the end of January. The beneficiary promptly applies for a new Part D plan, and the new PDP sponsor receives a completed enrollment request on January 28 for a February 1 effective date.

If the individual in the above example did not enroll in another PDP on January 28th, s/he would have an additional 90 calendar days from the effective date of the disenrollment from the first PDP to elect another PDP. The individual may choose an effective date of enrollment in a new PDP beginning any of the three months after the month in which the PDP sponsor receives the completed enrollment request. However, the effective date may not be earlier than the date the PDP sponsor receives the completed enrollment request.

> **EXAMPLE**
> On January 16, CMS determines, based on a member's allegations that the PDP sponsor substantially violated a material provision of its contract. As a result, the member disenrolls from the PDP on January 31. A 90-day SEP continues to exist for the beneficiary from

February 1 through April 30. In this example, a new PDP sponsor then receives a completed enrollment request from the individual on April 15. The beneficiary may 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 enroll in another Part D plan. Depending on the circumstance surrounding the contract violation, CMS may determine a retroactive enrollment into another plan is warranted.

30.3.4 - SEPs for Non-renewals or Terminations

In general, SEPs are established to allow members affected by PDP non-renewals or terminations ample time to make a choice of another PDP. Effective dates during these SEPs are described below. CMS has the discretion to modify this SEP as necessary for any non-renewal or termination when the circumstances are unique and warrant a need for a modified SEP.

In particular:

- **Non-renewals -** An SEP exists for members of a PDP that will be affected by a plan or contract non-renewal that is effective January 1 of the contract year. For this type of non-renewal, PDP sponsors are required to provide advance notice to affected members within timeframes specified by CMS. 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.

- **PDP Sponsor Termination of Contract and Terminations/Contract Modifications by Mutual Consent -** An SEP exists for members of a PDP who will be affected by a termination of contract by the PDP sponsor or a modification or termination of the contract by mutual consent (see 42 CFR §423.508 for contract requirements regarding terminations). 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 enroll in another PDP before the termination effective date, he/she will be disenrolled 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 enroll in a PDP (for a prospective, 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 PDP sponsor receives the enrollment request.

EXAMPLE
If a PDP sponsor 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 in a new PDP; however, the effective date may not be earlier than the date the new PDP sponsor receives the enrollment request.

- **CMS Termination of PDP Sponsor Contract -** An SEP exists for members of a PDP that will be affected by PDP sponsor contract terminations by CMS (see 42 CFR §423.509 for contract requirements on terminations). For this type of termination, PDP sponsors are required to give notice to affected members at least 30 calendar days prior to the effective date of the termination (see 42 CFR §423.509(b)(1)(ii)). To coordinate with the notification time frames, 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 enroll in a new PDP before the termination effective date, he/she will be disenrolled 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 enroll in another PDP (for a prospective, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may choose 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 PDP sponsor receives the enrollment request.

  EXAMPLE
  If CMS terminates a PDP sponsor 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 PDP sponsor receives the enrollment request.

- **Immediate Terminations By CMS -** CMS will establish the SEP during the termination process for immediate terminations by CMS (see 42 CFR §423.509(b) (2) for immediate termination requirements), where CMS provides notice of termination to the PDP enrollees and the termination may be mid-month.

Note: 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 plan consolidations.

30.3.5 - SEP for Involuntary Loss of Creditable Prescription Drug Coverage

This SEP applies to individuals who involuntarily lose creditable prescription drug 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 the individual's failure to pay premiums. The SEP permits enrollment in a PDP and begins with the month in which the individual is advised of the loss of creditable coverage and ends 2 months after either the loss (or reduction) occurs or the individual received the 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 2 months from the end of the SEP.

30.3.6 - SEP for Individuals Not Adequately Informed about Creditable Prescription Drug Coverage

This SEP applies to individuals who were not adequately informed of the creditable status of drug coverage provided by an entity required to give such notice, or a loss of creditable coverage. This SEP permits one enrollment in, or disenrollment from, a PDP on a case-by-case-basis. This SEP begins the month the individual receives CMS approval of the SEP and continues for two additional months following this approval.

30.3.7 - SEP for Enrollment/Non-enrollment in Part D due to an Error by a Federal Employee

An individual whose enrollment or non-enrollment in Part D is erroneous due to an action, inaction or error by a Federal Employee is provided an SEP. This SEP permits enrollment in or disenrollment from a PDP on a case-by-case basis. This SEP begins the month the individual receives CMS approval of the SEP and continues for two additional months following this approval.

30.3.8 - 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 enrolling in employer/union group-sponsored Part D plans, for individuals to disenroll from a Part D plan to take employer/union-sponsored coverage of any kind, and for individuals disenrolling from employer/union-sponsored coverage (including COBRA coverage) to enroll in a Part D plan. The SEP EGHP may be used when the EGHP allows the individual to make changes to their plan 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 plan and ends 2 months after the month the employer or union coverage ends.

The individual may choose the effective date of enrollment or disenrollment, up to 3 months after the month in which the individual completes 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 Medicare.

Refer to §30.4 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.

Keep in mind that all PDP eligible individuals, including those in EGHPs, may enroll in a PDP during the IEP for Part D, AEP and during any other SEP. The SEP EGHP does not eliminate the right of these individuals to enroll or disenroll during these time frames. Additionally, §60.5 outlines special processes that are available for enrollment into or disenrollment from EGHP sponsored Part D plans.

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 a PDP sponsor, 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 in an HMO or CMP under a §1876 cost contract that will no longer be offered in the area in which the beneficiary resides. Beneficiaries electing to enroll in a PDP via this SEP must meet PDP 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 a PDP at any time in order to enroll in PACE, including the PACE Part D benefit. In addition, individuals who disenroll from PACE have an SEP for up to 2 months after the effective date of PACE disenrollment to enroll in a PDP. The effective date would be dependent upon the situation.

5. SEP for Institutionalized Individuals – An SEP will be provided to an individual who moves into, resides in, or moves out of a:

- 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 that has an agreement under §1883 of the Act (a swing-bed hospital).

In addition, for individuals who move out of one of the facilities listed above, the individual will have an SEP for up to 2 months after he/she moves out of the facility. This SEP permits an individual to enroll in, or disenroll from, a Part D plan. The effective date is the first of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

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.

6. SEP for Individuals Who Enroll in Part B during the Part B General Enrollment Period (GEP) – An SEP will be provided to individuals who are not entitled to premium free Part A and who enroll in Part B during the General Enrollment Period for Part B (January – March) for an effective date of July 1st. The SEP will begin April 1st and end June 30th, with an effective date of July 1st.

7. 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 enrollments under this SEP will be prospective, effective the first day of the month following receipt of the enrollment request by the plan.

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 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 process will have an SEP that begins the month they are notified by the PDP and continues for two months.

8. Part D SEPs to Coordinate With MA Enrollment Periods – The following Part D SEPs are established to coordinate with election periods in the MA program. More information about MA

election periods can be found in MA Enrollment and Disenrollment Guidance (MMCM Chapter 2).

A. SEP for MA-PD enrollee using the MA SEP65 - MA eligible individuals who elect an MA plan during the initial coverage election period (ICEP) surrounding their 65th birthday have an SEP called the "SEP65." The SEP65 allows the individual to disenroll from the 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. If the individual using the SEP65 is disenrolling from an MA-PD plan, he or she may (but is not required to) use this Part D SEP to enroll in a PDP plan. This SEP must be used at the same time the SEP65 is used.

B. 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" – Individuals who dropped a Medigap policy when they enrolled for the first time in an MA plan are provided 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. If the individual is using this SEP to disenroll from an MA-PD plan, there is a Part D SEP to permit a one-time enrollment into a PDP. This SEP opportunity may only be used in relation to the MA SEP described here and begins the month they disenroll from the MA-PD plan and continues for two additional months.

C. SEP for an MA-PD enrollee using the MA Open Enrollment Period for Institutionalized Individuals (OEPI) to disenroll from an MA-PD plan - Individuals that meet the definition of "institutionalized" as it is provided in, and applies to, section 30.3.2 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2) are eligible for the OEPI election period. An individual disenrolling from an MA-PD plan has an OEPI to enroll in a PDP. This OEPI begins with the month the individual requests disenrollment from the MA-PD plan and ends on the last day of the second month following the month MA-PD membership ended.

D. SEP to enroll in a PDP - MA enrollees using the MADP to disenroll from MA – MA enrollees using the Medicare Advantage Disenrollment Period (MADP) to disenroll from MA from January 1 through February 14 may request enrollment in a PDP at any time during the MADP. This SEP permits one enrollment and ends when the individual has enrolled in the PDP**.** 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. 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 plan.

The effective date of this SEP is always prospective for the first of the month following receipt of the enrollment request. Therefore, an individual who uses this SEP in January will have an effective date of February 1, while an individual who uses this SEP from February 1 through February 14 will have an effective date of March 1. The SEP ends when the individual enrolls in a PDP or after February 14, whichever comes first.

E. SEP for enrollment into MA SNPs or enrollment into a PDP after loss of special needs status - CMS is establishing an SEP to allow for disenrollment from a PDP at any time in order to enroll in an MA SNP. In addition, CMS will provide an SEP to enroll in a PDP for those who are no longer eligible for a SNP because they no longer meet special needs status (as outlined in MA Enrollment and Disenrollment Guidance – MMCM, Chapter 2). This SEP begins the month the individual's special needs status changes and ends the earlier of when the beneficiary makes an election or three months after the effective date of the involuntary disenrollment. The effective date would be dependent upon the situation.

F. 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/disabling condition Special Needs MA-PD Plan will have an SEP to enroll in a different MA-PD plan or 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 failure to qualify 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.

G. SEP for Individuals Involuntarily Disenrolled from an MA-PD plan due to loss of Part B - Individuals who are involuntarily disenrolled from an MA-PD plan due to loss of Part B but who continue to be entitled to Part A have a SEP to enroll in a PDP. The SEP begins when the individual is advised of the loss of Part B and continues for two additional months.

H. SEP for Individuals Using the 5-Star SEP to Enroll in a 5-Star Plan without Part D Coverage – Individuals who use the 5-star SEP to enroll in a 5-star Medicare Advantage-only Private Fee-for-Service plan or a 5-star cost plan have a SEP to enroll in a PDP or in the cost plan's optional supplemental Part D benefit, for which they are eligible. The PDP selected using this coordinating SEP does not have to be 5-Star rated. However, individuals may not use this coordinating SEP to disenroll from the plan in which they enrolled using the 5-star SEP.

This SEP beings the month the individual uses the 5-Star SEP and continues for two additional months.

Note: Individuals who use the 5-Star SEP to enroll in a Medicare Advantage coordinated care plan are not eligible for this coordinating Part D SEP and must wait until their next valid election period in order to enroll in a plan with Part D coverage.

I. SEP to enroll in a PDP - MA enrollees using the "SEP for Significant Change in Provider Network" to disenroll from an MA Plan – MA enrollees using the "SEP for Significant Change in Provider Network" to disenroll from an MA plan may request enrollment in a PDP. This coordinating SEP begins the month the individual is notified of the network change and continues for an additional two months. This SEP permits one enrollment and ends when the individual has enrolled in the PDP**.** An individual may use this SEP to request enrollment in a PDP subsequent to having submitted a disenrollment to the MA plan or may simply request enrollment in the PDP, resulting in automatic disenrollment from the MA plan. Enrollment in the PDP is effective the first day of the month after the plan sponsor receives the enrollment request.

9. SEP for Individuals who belong to a Qualified SPAP or who lose SPAP eligibility -- Individuals who belong to a qualified SPAP are eligible for an SEP to make one enrollment choice at any time through the end of each calendar year (i.e., once per calendar year). SPAP members, or the State acting as the authorized representative of 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 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 the notification of the loss, whichever is later. This SEP permits an enrollment choice in another PDP or MA-PD.

10. Full-Benefit Dual Eligible individuals With Retroactive Uncovered Months – In limited instances, a full-benefit dual eligible voluntarily enrolls in a Part D plan in the month(s) before the individual would otherwise have been auto-enrolled. Due to the earlier enrollment a coverage gap may occur. To reduce the impact of the coverage gap, the beneficiary may enroll in the Limited Income NET program for those retroactive months per Section 40.1.4.B.

11. 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.

12. SEP for Individuals disenrolling from a Cost plan who also had the Cost plan optional supplemental Part D benefit – Individuals who disenroll from a cost plan and the cost plan's optional supplemental Part D benefit have an SEP to enroll in a PDP. This SEP begins the month the individual requests disenrollment from the cost plan and ends when the individual makes an enrollment election or on the last day of the second month following the month cost plan membership ended, whichever is earlier.

13. 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 between December 8 of the year prior to the year in which the plan sponsor has been granted a 5-star overall rating and November 30 of the year in which the sponsor 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 1:** 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 2:** 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 a PDP, an MA plan, a cost plan or Original Medicare to an MA-only plan, an MA-PD plan, a cost plan or a PDP that has a 5-star overall rating.

An individual using this SEP can enroll in an MA-only plan, an MA-PD plan, 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 then must wait for a subsequent enrollment period to obtain Part D coverage under the normal enrollment rules. Late enrollment penalties might also apply.

14. SEP for Non-U.S. Citizens who become Lawfully Present – CMS will provide an SEP for non-U.S. citizens who become lawfully present in the United States. The individual may use this SEP to request enrollment in any PDP for which he or she is eligible, including an MA-PD. This SEP begins the month the lawful presence starts and ends when the individual makes an enrollment request or two (2) full calendar months after the month it begins, whichever occurs first.

30.4 - Effective Date of Enrollment

With the exception of some SEPs and when enrollment periods overlap, generally beneficiaries may not request their effective date of enrollment in a PDP. Furthermore, unless provided for under an SEP (e.g. EGHP or full dual retroactive as discussed in the previous section), the effective date can never be prior to the receipt of an enrollment request by the PDP sponsor. An enrollment cannot be effective prior to the date the beneficiary (or their legal representative, if applicable) completed the enrollment request. The effective date also may not be earlier than the first day of the individual's entitlement to Medicare. This section 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.

To determine the proper effective date, the PDP sponsor must determine which enrollment period applies to each individual before the enrollment may be transmitted to CMS. This period may be determined by reviewing information such as the individual's date of birth, Medicare card, and by the date the PDP sponsor receives the enrollment request.

Once the PDP sponsor identifies the enrollment period, the PDP sponsor must determine the effective date. In addition, PDP enrollments for EGHP sponsored PDP plans and full benefit dual eligible enrollments may be retroactive under certain circumstances (refer to §60.5 for more information on EGHP retroactive effective dates).

Examples for determining the effective date:

A. On August 18, 2010, Mrs. Jones submits an enrollment request to a PDP sponsor. Her enrollment form shows she became entitled to Medicare Parts A and B in March 2002.

She has indicated on her enrollment form that she lives in a long-term care facility. What is her effective date?

Explanation: Since the date the request was received is August 18, 2010, this is not an AEP request. The entitlement date for Medicare Parts A and B shows that she is not in her IEP for Part D. That leaves only an SEP. Mrs. Jones indicated that she resides in a long-term care facility, so this enrollment request can be processed under the SEP for Institutionalized Individuals (see §30.3.8, item # 5). The effective date for this enrollment is September 1, 2010.

B. Mr. Doe calls a PDP sponsor for information about Part D on October 3, 2010. The PDP representative discusses the PDP plans available and the enrollment requirements, including when an individual may enroll. Mr. Doe tells the representative that he is retiring and his employer coverage will end on October 31, 2010. He submits an enrollment request on October 24, 2010. His entitlement to Medicare Parts A and B is June 1, 1998. He indicates on the request that he does not reside in a long-term care facility.

Explanation: Since the date the request was received is October 24, 2010, this is not an AEP request. The entitlement date for Medicare Parts A and B shows he is not in his IEP for Part D. No other details on the request itself point to any specific enrollment period, however we know that he has retired and his employer sponsored commercial coverage is ending. The enrollment can be processed using the SEP EGHP (see §30.3.8, item # 1). Mr. Doe can choose an effective date of up to 3 months after the month in which the request is made. The PDP sponsor contacts Mr. Doe, confirms his retirement, explains the SEP EGHP and asks him about the effective date. Since his employer coverage is ending on October 31, 2010, he requests a November 1, 2010, effective date.

Effective dates for Enrollment Periods:

Part D Enrollment Period	**Effective Date**
Annual Election Period (AEP) The AEP begins on October 15 and continues through December 7 of every year. Individuals have one AEP enrollment to use – once this enrollment is effective, the AEP has been used.	January 1st of following year.

Initial Enrollment Period for Part D (IEP for Part D) For individuals that become Part D eligible after January 2006, generally the IEP for Part D is concurrent with the initial enrollment period for Part B. (Note: The Initial Enrollment Period for Part B begins 3 months prior to the month of Medicare eligibility, and ends on the last day of the third month following the month of Medicare eligibility.) Example: Mrs. Jones is eligible for Medicare on July 1, 2010. Her Part B Initial Enrollment Period is April 1, 2010 through October 31, 2010. Therefore her IEP for Part D is also April 1, 2010 through October 31, 2010. If individuals had not been eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B or those not eligible for Part D during first Medicare initial enrollment period for Part D that occurred from November 15, 2005 through May 15, 2006, their IEP for Part D is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D. Individuals eligible for Medicare prior to age 65 (such as for disability) will have another IEP for Part D based upon attaining age 65.	Enrollment requests made prior to the month of eligibility are effective the first day of the month of eligibility. Enrollment requests made during or after the first month of eligibility are effective the 1st of the month following the month the request was made.
Special Enrollment Periods (SEP) SEPs for PDP enrollment and disenrollment choices are described in section 30.3 of this guidance.	Effective dates are dependent upon the individual SEP and circumstances.

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. If a sponsor receives an enrollment request and determines the applicant is eligible for more than one election period, the sponsor must allow the individual to choose the enrollment effective date (see exception in the next paragraph regarding the IEP for Part D). To accomplish this, the sponsor 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 IEP for Part D, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

EXAMPLE
If an individual's IEP for Part D starts in November, (i.e., he will be entitled to Medicare Part A and Part B in February) and a PDP sponsor receives an enrollment request from that individual during the AEP, then the individual may NOT choose a January 1 effective date (for the AEP) and must instead be given a February 1 effective date (for the IEP for Part D) because January 1st is earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

If an individual is eligible for more than one enrollment period but does not indicate a preferred effective date, or the organization is unable to contact the individual, the PDP sponsor must assign an effective date using the following ranking of enrollment periods. The enrollment period with the highest rank determines the effective date in this situation.

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 Enrollment Periods: (1 = Highest, 3 = Lowest)

1. IEP for Part D

2. SEP

3. AEP

30.5 - Effective Date of Voluntary Disenrollment

PDP enrollees may voluntarily disenroll from a PDP during the AEP and SEP as described in §§20.2 and 20.3 of this guidance. With the exception of some SEPs and when enrollment periods overlap, generally beneficiaries may not choose the effective date of disenrollment. This section 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.

A PDP enrollee may disenroll through the PDP sponsor or 1-800-MEDICARE. If an enrollee enrolls in a new PDP, during an available enrollment period, while still enrolled in another PDP, he/she will automatically be disenrolled from the old PDP and enrolled in the new PDP by CMS systems with no duplication or delay in coverage. Further, individuals enrolled in any MA plan (except for an MA Private Fee-For-Service (PFFS) plan that does not offer a Part D benefit or a Medicare Medical Savings Account (MSA) plan) will be disenrolled from that MA plan upon successful enrollment in a PDP.

As with enrollments, it is possible for an individual to make a disenrollment request when more than one enrollment period applies. Therefore, in order to determine the proper effective date, the PDP sponsor must determine which period applies to the request to determine the effective date of disenrollment before the disenrollment transaction may be transmitted to CMS.

If a PDP sponsor receives a disenrollment request when more than one period applies, the PDP sponsor must allow the member to choose the effective date of disenrollment (from the possible dates, as provided by the enrollment/disenrollment periods that overlap). If the member does not make a choice of effective date, then the PDP sponsor must give the effective date that results in the **earliest** disenrollment. The procedure for determining the enrollment/disenrollment period is the same as described in §30.4 of this guidance.

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

Enrollment Period	**Effective Date of Disenrollment***	**Do PDP sponsors have to accept disenrollment requests in this enrollment period?**
Annual Election Period	January 1 of the following year.	Yes
Special Enrollment Period	Varies, as outlined in §20.3	Yes

***NOTE:** CMS may allow up to 90 days retroactive payment adjustments for EGHP sponsored PDP disenrollments. Refer to §60.5 for more information.

As stated previously, individuals generally cannot choose the effective date of disenrollment. The enrollment/disenrollment period during which the request is received dictates the effective date. If an individual requests a disenrollment date that is not permissible, the PDP sponsor should advise the individual and process the request according the requirements in this guidance.

40 - Enrollment Procedures

42 CFR 423.32

A PDP sponsor must accept all enrollment requests it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, through CMS auto-enrollment or facilitated enrollment processes, or through other mechanisms defined by CMS (and offered by the PDP sponsor). PDP sponsors may accept faxed enrollment requests and need not obtain the original.

Upon receiving an enrollment request, a PDP sponsor must provide within 10 calendar days, one of the following:

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

If a sponsor uses the combined acknowledgment/confirmation notice, the sponsor 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).

The individual (or his/her legal representative) must complete an enrollment request and include all the information required to process the enrollment, or an enrollment may be generated by other processes specified by CMS. Furthermore, the individual must submit the election to the PDP during a valid enrollment period.

Unless otherwise directed in this guidance, the PDP sponsor must provide notice in response to information received from CMS on the TRR that contains the earliest notification.

Special Rule for the Annual Election Period (AEP):

PDP sponsors 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 PDP sponsors may not accept or solicit submission of paper enrollment forms prior to the start of the AEP. PDP sponsors 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 PDP sponsors 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 PDP sponsor 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 a PDP sponsor 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 complete paper enrollment request, the plan must provide the beneficiary with a written notice that acknowledges receipt of the enrollment request (Exhibit 2), and indicates that the enrollment will take effect on January 1st effective date of the following year.

- For unsolicited AEP enrollment requests received prior to the start of the AEP, sponsors 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 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 PDP sponsor receives a MARx TRR from CMS indicating whether the individual's enrollment has been accepted or rejected, the PDP sponsor 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) provided in Section 40.4.

Note: If sponsors 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.

Again, this policy applies only to unsolicited paper enrollment forms requesting an AEP enrollment for January 1st. To help ensure a successful AEP season, it is imperative that sponsors follow these steps and submit valid enrollment transactions promptly as directed.

40.1 - Format of Enrollment Requests

All PDP sponsors must have, at minimum, a paper enrollment form available for potential enrollees to request enrollment in a PDP. PDP sponsors may also accept enrollment elections made via the on-line enrollment center hosted by CMS, as well as requests for enrollment as described in §§40.1.1 – 40.1.6.

No PDP enrollment request vehicle, regardless of format, may include any question regarding health screening information.

The PDP sponsor's enrollment vehicle(s) must include important information that the individual acknowledges, including:

- Understands the requirement to continue to keep Medicare Part A or B

- Agrees to abide by the PDP sponsor's membership rules as outlined in material provided to the member;

- Consents to the disclosure and exchange of information necessary for the operation of the Part D program;

- Understands that enrollment in the PDP automatically disenrolls him/her from any other PDP or MA plan (as described in §20 of this guidance) in which he/she is enrolled; and

- Knows he/she has 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 – 1b 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. Sponsors 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.

Refer to §60.8 for requirements regarding retention of enrollment requests.

40.1.1 - Paper Enrollment Forms

All PDP sponsors must, as a minimum standard, have a paper enrollment form that complies with CMS' guidelines in format and content and a process as described in
this guidance for accepting it. A model enrollment form is included in Exhibit 1 and Exhibit 1b.

40.1.2 – Electronic Enrollment

PDP sponsors may develop and offer electronic enrollment mechanisms made available via an 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 individuals with all the information required by CMS' marketing guidelines for the Part D program.
- At a minimum, comply with CMS' data security policies.
- Advise each individual at the beginning of the electronic enrollment process that he or she is completing an actual enrollment request to the PDP sponsor.
- Capture the same data as required on the model enrollment form (see Exhibit 1, 1b 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 or 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 1b), 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 and date stamp at the time the applicant activates the step in the previous bullet (i.e. "Enroll Now or I Agree" button or tool). The PDP sponsor 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 PDP sponsor.**
- If a legal representative is completing this enrollment request, he or she must attest that he or she has such authority to make the enrollment request and that proof of this authority is available upon request by the PDP sponsor or CMS.
- Inform the individual of the effects of completing the electronic enrollment, including that the individual will be enrolled (if approved by CMS), and that he or she 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 PDP sponsor 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 §60.8 of this chapter. The PDP sponsor'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.
- Plans have the option of obtaining technical and related services from outside entities in support of the PDP sponsor's electronic enrollment mechanism(e.g. licensed software). Sponsors may use downstream entities, such as a broker or third party website, as a means of facilitating and capturing the electronic enrollment request. However, sponsors retain complete responsibility for ensuring enrollment policies in this guidance are followed, and for ensuring the appropriate handling of any sensitive beneficiary information provided as part of the online enrollment, including those facilitated by downstream entities.
- From the point at which an individual selects the plan of his or her choice on the third-party website and begins the online enrollment process, CMS holds the organization responsible for the security and privacy of the information provided by the applicant and for the timely disclosure of any breaches.

Medicare Online Enrollment Center

In addition to the process described above, CMS offers an online enrollment center (OEC) through the Medicare.gov website and the 1-800-MEDICARE Call Center for enrollment into Medicare prescription drug plans. The date and time "stamped" by the Medicare OEC will serve as the application date for purposes of determining the election period and enrollment effective date. PDP sponsors must promptly retrieve enrollment requests from the OEC and should check for requests at least daily.

40.1.3 - Enrollment via Telephone

PDP sponsors may accept enrollment requests into one or more of its PDPs via an incoming (in-bound) telephone call to a plan representative or agent. The following guidelines must be followed, in addition to all other program requirements:

- Enrollment requests may only be accepted from/during an incoming (or in-bound) telephone call from a beneficiary to a plan representative or agent.
- The PDP sponsor 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 and include statements of the individual's agreement to be recorded, 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 §60.8 of this guidance.
- 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 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 of this guidance.
- Telephonic enrollment requests into a plan offered by the same parent organization may be based on the model short enrollment form (Exhibit 1b) or the model plan selection form (Exhibit 1c) instead of the comprehensive individual enrollment form.

The PDP sponsor must ensure that all Part D eligibility and enrollment requirements provided in this guidance are met.

Scripts for completing an enrollment request in this manner must be developed by the PDP sponsor must contain the required elements for completing an enrollment request as described in Appendix 2 of this guidance, and must obtain CMS approval following existing marketing material approval procedures prior to use.

40.1.4 - Auto- and Facilitated Enrollment

CMS auto-enrolls and facilitates enrollment of certain LIS beneficiaries into PDPs. "Auto-Enrollment" is the process that refers to full-benefit dual eligible individuals. "Facilitated Enrollment" is the process that refers to other LIS beneficiaries. The primary differences between the two are the populations and the enrollment effective date.

Starting January 1, 2010, CMS implemented the Limited Income Newly Eligible Transition (NET) demonstration, in which it contracts with a single PDP sponsor to cover all periods of retroactive auto/facilitated enrollments. The Limited Income NET demonstration contractor is competitively procured. As a result, all auto/facilitated enrollments to qualified PDPs as described below will have prospective effective dates.

A. Populations

1. <u>Auto-Enrollment</u>

Full-benefit dual eligible individuals who have not elected a Part D plan will be auto-enrolled into one by CMS. 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 Part B premiums and/or cost-sharing (sometimes known as QMB-plus or SLMB-plus). CMS will use data provided by State Medicaid Agencies to identify full-benefit dual eligible individuals. 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).

Full-benefit dual eligible individuals who will be auto-enrolled into a PDP pursuant to this section include those enrolled in:

- Original Medicare;
- A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit;
- An 1876 cost plan that does not offer a Part D optional supplemental benefit;
- Medical Savings Account; or
- An 1833 Health Care Prepayment Plan (HC-PP); and
- Who do not meet any of the conditions listed below.

This excludes full-benefit dual eligible individuals who:

- Live in any of the five U.S. territories
- Live in another country
- Are incarcerated, as defined in §10
- Are not lawfully present in the U.S.
- Have opted out of auto-enrollment into a Part D plan
- Are already enrolled in a Part D plan

Note: Beneficiaries enrolled in a Program of All Inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their PACE organization, so they do not need to be auto-enrolled

- Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan, other than an MA-PFFS plan that does not offer Part D or an MSA plan. CMS will instead direct Medicare Advantage organizations to facilitate the enrollment of these individuals into an MA-PD plan or PDP offered by the same MA organization; please see Section 40.1.5 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2).
- Are enrolled in a section 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be auto-enrolled instead into the cost plan's Part D optional supplemental benefit, as is described in Chapter 17, Subpart D, of the Medicare Managed Care Manual).

For modified auto-enrollment procedures for full-benefit dual eligible individuals for whom employers claim a retiree drug subsidy, please see section 40.1.4.H.

2. <u>Facilitated Enrollment</u>

Other LIS eligible individuals 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 subsidy. CMS will use data submitted by SSA to identify SSI-only and those who apply for LIS and are determined eligible by SSA. CMS will use data from State Medicaid Agencies to identify those who are QMB-only, SLMB-only, QI, or who apply for LIS and are determined eligible by the State.

Other LIS eligible individuals that will be enrolled into PDPs pursuant to this section include those enrolled in:

- Original Medicare;
- A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit;
- An 1876 cost plan that does not offer a Part D optional supplemental benefit;
- A Medical Savings Account (MSA); or
- An 1833 HCPP; and
- Who do not meet any of the conditions listed below.

  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 is claiming the retiree drug subsidy
  - Are incarcerated, as defined in §10
  - Are not lawfully present in the U.S.
  - Have opted out of facilitated enrollment into a Part D plan
  - Are already enrolled in a Part D plan

Note: Beneficiaries enrolled in a Program of All Inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their PACE organization, so they do not need to be auto-enrolled

- Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan other than an MA-PFFS plan that does not offer Part D or an MSA plan. CMS will instead direct Medicare Advantage organizations to facilitate the enrollment of these individuals into an MA-PD plan or PDP offered by the same MA organization; please see Section 40.1.5 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2)
- Are enrolled in an 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be facilitated enrolled instead into the cost plan's Part D optional supplemental benefit, as is described in Chapter 17, Subpart D, of the Medicare Managed Care Manual).

B. Qualifying PDPs

A PDP qualifies to receive auto/facilitated enrollments in a given region if it meets all the following criteria:

- offers basic prescription drug coverage
- has a premium at or below the low-income premium subsidy amount in the PDP region
- meets the "Requirements Critical for Ensuring Effective Enrollment of Dual Eligible individuals" issued August 31, 2006.

PDPs that qualify to receive auto/facilitated enrollments may not decline to accept such enrollments. Qualifying PDPs must accept all individuals assigned by CMS who had been previously involuntarily disenrolled by the plan for non-payment of premiums.

Only PDPs with defined standard, actuarially equivalent standard, or basic alternative benefit packages will be included. CMS will not auto/facilitate enroll beneficiaries into PDPs with enhanced alternative benefit packages, even if their premium is at or below the low-income premium subsidy amount for the region. In addition, CMS will not auto/facilitate enroll beneficiaries into an employer-sponsored PDP. Finally, CMS will not auto/facilitate enroll beneficiaries into PDPs that volunteer to waive the "de minimis" amount over the regional LIS benchmark.

Plans that qualify to receive auto/facilitated enrollments in the current year, but will not in the following year will no longer receive new auto- or facilitated enrollments starting in October of the current year. This avoids the need to immediately reassign these beneficiaries to a different plan.

PDPs that do not qualify in the current year, but do qualify in the following year, will start receiving PDP Notification Files and TRRs with auto/facilitated enrollments starting November of the current year (with effective dates no earlier than January 1 of the following year).

Starting January 1, 2010, only the Limited Income NET contractor will qualify to receive auto/facilitated enrollments for retroactive periods of time. The Limited Income NET contractor will not keep these individuals on a prospective basis.

C. Auto/Facilitated Enrollment Process

CMS performs the auto/facilitated enrollment process each day it receives a source file from a State Medicaid Agency or Social Security Administration. The procedures for auto- and facilitated enrollment into PDPs are identical, and work as follows:

1. CMS will identify full-benefit dual eligible individuals to be auto-enrolled and other LIS eligible individuals to be facilitated enrolled. CMS uses LIS deemed reason code, which indicates the person was a full benefit dual eligible sometime during the past year, to define those being auto-enrolled. LIS deemed code and LIS applicant data are used to identify those who need to be facilitated enrolled.

2. CMS will identify PDPs that qualify to receive auto/facilitated enrollments.

3. CMS will assign beneficiaries to a plan in a two-step process. The first level of assignment is at the PDP sponsoring organization (PDP Sponsor) level. The second level of assignment is to an individual PDP offered by the PDP Sponsor. This will result in approximately the same proportion of auto-enrollees at the PDP Sponsor level.

   At the first level of assignment, CMS will identify PDP sponsors that offer at least one qualifying PDP in the region. If more than one PDP sponsor in a region meets this criteria, CMS will auto/facilitate enroll on a random basis among available PDP sponsors. Please note that if two or more PDP sponsors are owned by the same parent organization, they are treated as a single organization for purposes of this first step of auto/facilitated enrollment.

   At the second level of assignment, CMS will identify the qualifying PDPs offered by each sponsor in the region. If a given PDP sponsor only has one such PDP in the region, all the beneficiaries assigned to the PDP sponsor will be assigned to that one PDP. If the PDP sponsor offers more than one such PDP in the region beneficiaries will be randomly assigned first among the contracts within the sponsoring organization (if there are more than one with a qualifying PDP), and then among the qualifying PDPs a contract offers..

   This method of random enrollment will result in full-benefit dual eligible individuals and other LIS beneficiaries being assigned in approximately equal proportions among available PDP sponsors, not PDPs. Since PDP sponsors may offer different numbers of PDPs that meet the auto/facilitated enrollment criteria, auto/facilitated enrollment proportions may vary at the PDP level.

   EXAMPLE:

   There are 4 PDP-sponsoring organizations in a region that offer one or more plans with premiums at or below the low income premium subsidy amount. The numbers of PDPs with an appropriate premium are as follows:

Organization A—1 PDP
Organization B—1 PDP
Organization C—2 PDPs
Organization D—3 PDPs

Step 1: The auto/facilitated enrollment population would first be divided equally and randomly among the four PDP sponsors. Thus, each PDP sponsor would be assigned 25 percent of the available population.

Step 2: Within each PDP sponsor, the population would again be divided equally and randomly. Thus, all of Organization A's enrollees would be assigned to its one appropriate PDP; the same would be true for Organization B; 50 percent of the population assigned to Organization C would be assigned randomly to each of its two plans; and 33.3 percent of the population assigned to Organization D would be assigned randomly to each of its three plans.

PDPs with premiums below the low-income subsidy amount will not be treated more favorably than those with premiums equal to the low-income premium subsidy amount. A PDP's other beneficiary charges – copayment levels, deductibles, etc. – will not be a factor in determining whether it qualifies for auto/facilitated enrollment provided the PDP offers basic prescription drug coverage.

4. CMS will calculate the effective date as the first day of the second month after the current month (see section 40.1.4.D below for details), create a code 61 enrollment transaction for each auto and facilitated enrollment, and submit it to the MARx system.

5. Immediately after auto/facilitated enrollment occurs, the PDP will receive the preliminary "PDP notification file" identifying those assigned, including addresses and full names. CMS does not maintain phone number data on beneficiaries, so this information cannot be transmitted to PDP sponsors. This file ensures PDPs are notified of new auto/facilitated enrollees prior to beneficiaries receiving CMS' auto/facilitated enrollment notice. Since auto/facilitated enrollment can occur daily, these files may be transmitted as frequently as daily.

6. The PDP will then be notified via TRR of the auto/facilitated enrollment confirmed processed by MARx, including the effective date.

For technical specifications and file formats, please see sections 8.2 and E.2 of the Plan Communications User Guide, on the CMS website at http://www.cms.hhs.gov/MMAHelp/02_Plan_Communications_User_Guide.asp.

D. Effective Date

Starting January 1, 2010, all auto/facilitated enrollments generated by CMS into qualifying PDPs will have prospective effective dates. Specifically, the effective date will be the first day of the second month after CMS identifies the person.

> **Example**: Throughout 2010, an individual is eligible for Part D. On July 14, 2010, the State sends data to CMS identifying the person as a full or partial dual, or SSA sends data to CMS identifying the person as a new SSI-only or LIS applicant, retroactive to March 1, 2010. CMS randomly auto/facilitate enrolls the person into a qualifying PDP effective September 1, 2010. If the person was a full dual or SSI-only, CMS creates a second auto/facilitated enrollment transaction into the Limited Income NET contractor for March 1 – August 31, 2010.

CMS will calculate the auto/facilitated enrollment effective date, which will be conveyed to plans in the PDP Notification File and the TRR. CMS will ensure that any beneficiary choice will "trump" facilitated enrollment by creating an artificially early application receipt date for systems processing purposes.

For retroactive periods, CMS will auto/facilitate enroll full-benefit dual eligible individuals and SSI-only beneficiaries into the Limited Income NET contractor. Please see below for details on when retroactive periods of coverage are necessary and how they are calculated.

1. Retroactive Auto/Facilitated Enrollments for Full Duals and SSI-Only

Full-benefit dual eligible individuals and SSI-only beneficiaries may qualify to be retroactively auto/facilitated enrolled by CMS into the Limited Income NET contractor. Partial dual eligible individuals and LIS applicants do not qualify for retroactive assignments.

For full-benefit dual eligible individuals who are Medicaid eligible first and then subsequently become Medicare eligible, the effective date of auto-enrollment will be the first day of Part D eligibility. This effective date ensures there is no coverage gap between the end of Medicaid prescription drug coverage and the start of Medicare prescription drug coverage. CMS will make every effort to identify these individuals prior to the start of their Part D eligibility, so that we can notify beneficiaries and plans prospectively of auto-enrollment. However, in cases where we cannot do so, the enrollment may be retroactive. Please note that Part D eligibility always falls on the first day of the relevant month.

> **Example:** An individual has Medicaid coverage throughout 2010. On March 15, 2010, the State sends data identifying the person as a prospective full dual, who will become Medicare Part D eligible in May, 2010. That night, CMS randomly auto-enrolls the person into a qualifying PDP effective May 1, 2010. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2010.

Retroactive eligibility for Medicare Parts A and/or B will not result in retroactive effective dates for auto-enrollment. This is because Medicare Part D eligibility cannot be retroactive. If

eligibility for Part A and/or B is retroactive, Part D eligibility is effective the first day of the month in which the beneficiary received notification of retroactive Medicare Part A/B entitlement (see §10).

> **Example:** An individual has Medicaid coverage throughout 2010. In May 2010, the individual is notified that s/he is entitled to Medicare Part A and/or B retroactive to November, 2009. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2010; the first day of Part D eligibility is May 1, 2010. The person is included on a state MMA file on May 20; CMS auto-enrolls the beneficiary into the Limited Income NET contractor for May 1 through June 30, 2010; and randomly auto-enrolls her/him into a qualifying PDP effective July 1, 2010.

For those who are Medicare eligible first, and then subsequently become Medicaid eligible, auto-enrollment will be effective the first day of the month the person became Medicaid eligible (i.e. achieved full-benefit dual status), or January 1, 2006, whichever is later. For this population, there are no data that can be used to identify them prospectively, so the effective date will likely always be retroactive. Please note that auto-enrollment will only occur if the beneficiary is not already enrolled in a Part D plan; if the person is already in a Part D plan, the only impact of becoming newly eligible for Medicaid is that the individual will be deemed eligible for the full low-income subsidy.

> **Example**: An individual is Medicare Part D eligible through 2010. The person applies for Medicaid in August 2010, is determined in October, 2010 to be Medicaid-eligible back to August 1, 2010, and is included on a state MMA file in October. Because the person has Medicare, she/he is not eligible for Medicaid prescription drug coverage (note she/he remains eligible for other Medicaid benefits). CMS auto-enrolls the beneficiary into the Limited Income NET contractor retroactive to August 1, 2010, and randomly into a qualifying PDP effective December 1, 2010.

> **Example**: An individual becomes Medicare Part D eligible in May 2010. That same month, the individual applies for Medicaid. In August 2010, the State Medicaid Agency awards Medicaid eligibility effective February 1, 2010 (Medicaid eligibility may be retroactive to three months before the month of application), and includes the person on a state MMA file in August. In this scenario, Medicaid prescription drug coverage is effective February 1 – April 30, 2010. CMS auto-enrolls the beneficiary into the Limited Income NET contractor retroactive to May 1, 2010, and randomly auto-enrolls the person into a qualifying PDP effective October 1, 2010.

CMS will auto-enroll full-benefit dual eligible individuals who have disenrolled, either voluntarily or involuntarily, from a Part D plan and failed to enroll in a new plan (unless they affirmatively declined or opted-out of auto-enrollment). The effective date will be retroactive to the month after the disenrollment effective date of the previous Part D plan enrollment.

> **Example**: A full-benefit dual eligible or SSI-only eligible disenrolls from a Part D plan (either voluntarily or involuntarily), effective March 31, 2010. In the April auto/facilitated enrollment

run, CMS auto/facilitate enrolls the person into the Limited Income NET contractor effective April 1, and randomly into a qualifying PDP effective June 1, 2010.

In limited instances, a full-benefit dual eligible voluntarily enrolls in a Part D plan in the month(s) before the individual would otherwise have been auto-enrolled, or CMS auto/facilitates enrollment of a beneficiary with a given effective date, but subsequently data become available that shows the effective date should have been earlier. Individuals with active elections in a Part D plan are not included in CMS' auto-enrollment process, so the auto-enrollment process does not create an enrollment for the uncovered month(s). In these instances, the beneficiary contacts the Limited Income NET contractor to request coverage for the uncovered month(s) in the past. The current PDP must refer beneficiaries with uncovered months in the past to the LINET contractor to request coverage.

The PDP must move up the effective date of a facilitated enrollment by a month if the LIS beneficiary requests this in a timely fashion, i.e. before the start of the earlier month. The PDP must accept these requests verbally and in writing; it cannot limit such request to written requests. The beneficiary can contact the plan by telephone or in writing to make this request. If the person is a partial dual eligible, the SEP under section 30.3.2 should be used. If the person is an SSI-only eligible or an individual who applied and was determined eligible for LIS by SSA or a State Medicaid Agency, the SEP under section 30.3.8 #7 is available.

> **Example:** CMS facilitates enrollment of an Other LIS eligible in May, 2010, effective July 1, 2010. The beneficiary receives the facilitated enrollment notice in May, and by May 31 requests the PDP makes the facilitated enrollment effective June 1. The PDP submits an enrollment transaction to do so.

E. CMS Notice Provided to Auto/Facilitated Enrolled Beneficiaries:

CMS will notify the beneficiary that she/he will be auto/facilitated enrolled in a given PDP on the auto/facilitated enrollment effective date unless s/he chooses another Part D plan (either another PDP, or an MA-PD plan, a PACE organization, or an 1876 cost plan that offers a Part D optional supplemental benefit), or opts out of auto/facilitated enrollment into a Part D plan altogether. For beneficiaries who have a retroactive period of auto/facilitated enrollment, the notice will provide information on obtaining coverage for those periods through the Limited Income NET contractor. Auto-enrollment notices will be on yellow paper; facilitated notices will be on green paper. If the beneficiary does not take either action, the person's silence will be deemed consent with the auto/facilitated enrollment, and it will take effect on the effective date. Additionally, all LIS and dual eligible individuals have a Special Enrollment Period (SEP) that permits them to change Part D plans at any time, even after the auto/facilitated enrollment takes effect (refer to section 30.3.2 and 30.3.8, #7 of this guidance).

CMS has created an exception to the auto-enrollment procedures for full benefit dual eligible individuals who CMS knows to be enrolled in a qualifying employer group plan and for whom CMS has approved the group health plan sponsor to receive the Retiree Drug Subsidy (RDS) (see section 40.1.4.H). CMS will provide notice to such individuals of their choices and advise them to discuss the potential impact of Medicare Part D coverage on their group health plan coverage.

This notice informs such individuals that they will be deemed to have declined to enroll in Part D unless they affirmatively enroll in a Part D plan or contact CMS and confirm that they wish to be auto-enrolled in a PDP. Individuals, who elect not to be auto-enrolled, may enroll in Medicare Part D at a later time if they choose to do so.

F. PDP Notice and Information Provided to Auto/Facilitated Enrolled Beneficiaries:

PDPs must send a notice confirming the auto-enrollment (see Exhibit 24) or facilitated notice (see Exhibit 25) within 10 calendar days after receiving CMS confirmation of the enrollment from the TRR or the PDP Notification File with addresses of auto/facilitated enrollees, whichever is later.

PDPs must also send a modified version of the pre- and post-enrollment materials that must be provided to those who voluntarily enroll in a PDP. If the address indicates the beneficiary is outside the PDP region, please follow procedures in section 50.2.1.4.

Prior to the effective date, the PDP must send each individual who has been auto/facilitated enrolled:

- Proof of health insurance coverage so that he/she may begin using the plan services as of the effective date;

  NOTE: This is not the same as the Evidence of Coverage document described in CMS' marketing guidelines. This evidence may be in the form of member cards, the enrollment form, and/or a notice to the member. If the PDP sponsor does not provide the member card prior to the effective date, it must provide it as soon as possible after the effective date.

- The charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts (including general information about the low income subsidy);

- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the PDP sponsor has not yet provided the ID card); AND

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

The requirement in §40.4.2 (see also Exhibits 4 and 7) to inform the beneficiary of whether the enrollment was accepted or rejected does not apply to auto/facilitated enrollments, since CMS generates these transactions and they are already confirmed at the point when the sponsor is notified via the TRR.

There may be certain times during the month death information is updated in CMS records after the auto-assignment/enrollment process has occurred, resulting in auto-enrollment of individuals with a deceased code. In cases where the PDP sponsor receives an auto-enrollment with a deceased code, the PDP sponsor must send a notice to the estate of the member (see Exhibit 13a).

PDPs do not need to send the 30-day Coordination of Benefits survey for new enrollees whether they are auto or facilitated enrolled; they only need to conduct the annual survey.

G. Opt Out:

Full-benefit dual eligible and other LIS eligible individuals may opt out of (affirmatively decline) auto/facilitated enrollment into a Part D plan. The primary means for doing so is by calling 1-800-MEDICARE. However, the beneficiary may also call the PDP into which he/she has been auto/facilitated enrolled. The PDP may accept the request verbally; a written request is not required. The entity contacted by the beneficiary must inform the individual of the implications of his/her request. In addition, a follow-up notice must be provided that confirms the request to opt-out, and explains the consequences (see Exhibit 26). The entity then sends a Code 51 disenrollment transaction and sets the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment).

The beneficiary may opt-out either prior to the auto/facilitated enrollment effective date, or once enrolled in a Part D plan (whether voluntarily or auto/facilitated enrolled into it). If the beneficiary makes the request prior to the effective date of auto/facilitated enrollment, then the entity receiving the opt-out request will submit a disenrollment transaction (with specific coding indicating that the transaction is an opt-out). This will cancel the auto/facilitated enrollment, and the person will never be enrolled. The PDP sponsor should then send the model notice in Exhibit 26. If the beneficiary makes the request after the effective date of enrollment in the plan, then the request results in a disenrollment effective the last day of the month in which the request was made, and the model notice in Exhibit 26a should be used.

Please note that 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.

If the beneficiary decides she/he wants to obtain the Part D benefit in the future, she/he does so simply by enrolling in a new plan. LIS eligible individuals have a Special Enrollment Period, so they can enroll at anytime; they are not limited to the AEP.
The enrollment request will be effective the first of the month following the month in which the Part D plan receives the enrollment request.

H. Special Procedures for Full Benefit Dual Eligible individuals with Retiree Drug Subsidy

CMS has created an exception to the auto-enrollment process for full-benefit dual eligible individuals who are qualifying covered retirees and for whom CMS has approved the group health plan sponsor to receive the Retiree Drug Subsidy (RDS). The exception process includes:

- CMS identifies the full-benefit dual eligible individuals with RDS and excludes them from automatic enrollment in a Part D plan; and

- CMS sends a notice (see section 40.1.4.E) to these individuals
    - Informing them of their choices and that they need to proactively enroll in a Part D plan, if they wish to do so:
    - Suggesting that these individuals discuss the potential impact of their decision, on both drug and medical retiree benefits for themselves and their families, with the appropriate staff of the qualified retiree prescription drug plan; and
    - Indicating that they will be deemed to decline enrollment in Part D unless they affirmatively enroll in a Part D plan or contact CMS and confirm they wish to be auto-enrolled into a Part D plan.

40.1.5 - Re-Assignment of Certain LIS Beneficiaries

CMS has the discretion to re-assign LIS beneficiaries, including situations in which their current plan will have a premium above the low-income premium subsidy amount (i.e., benchmark) in the following year, unless the plan volunteers to waive the de minimis amount of the premium above the benchmark. CMS will conduct the reassignment in the fall of each year, and ensure all affected LIS beneficiaries are notified. Affected PDPs are not responsible for initiating any enrollment or disenrollment transactions for reassigned beneficiaries, except for re-enrollment of beneficiaries who opt to remain in their current plan, as described below. Affected PDPs are only responsible for responding to the CMS enrollment transaction promptly when they receive it and for providing appropriate beneficiary notices and materials, also as described below.

A. Population to be Re-Assigned

CMS will reassign beneficiaries enrolled in "Losing" PDPs who meet all of the following criteria:

For PDPs that offered a basic benefit and premium below the regional LIS benchmark in the current year, but will lose to reassign because they will have a premium in the following year that will be above the benchmark amount (unless they volunteer to waive the de minimis amount above the benchmark):

- They will continue to be eligible for 100% premium subsidy LIS in the following year. Individuals may qualify for 100% premium subsidy because they were deemed eligible for LIS (i.e., because they were a full benefit dual eligible, Medicare Savings Program participant, or Supplemental Security Income (SSI) recipient), OR because they applied and were found eligible for the 100% LIS premium subsidy).
- They were originally enrolled by CMS into their current PDP, i.e. through auto/facilitated enrollment, or reassignment.
- They do not live in a U.S. territory.

For PDPs that are non-renewing (terminating):

- All current LIS enrollees who will continue to have LIS in the following year, regardless of premium subsidy amount, and regardless of whether the individual was assigned to or voluntarily enrolled in a plan.

The actual reassignment process is typically run on a single day in early 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. "Losing" PDPs

A PDP will lose LIS beneficiaries to re-assignment if it meets any of the following criteria:

- The PDP has beneficiaries originally auto/facilitated enrolled or reassigned by CMS and there will be a new premium liability in the following year for those eligible for 100% premium subsidy under LIS. The premium increase would be due to the premium going above the LIS benchmark.

  Per 1860D-14(a)(5) of the Social Security Act, the PDP will not lose beneficiaries if:
  - The plan's premium is within a "de minimis" amount of the LIS benchmark, and
  - The plan voluntarily agrees not to collect the de minis premium amount over the benchmark (see section 40.1.5.B.1 below for additional details.

- The PDP is terminating for the following year.

As part of determining whether a terminating PDP should be included in reassignment, CMS determines whether it is truly non-renewing (i.e. all beneficiaries will be disenrolled with no automated enrollment into another PDP), or whether beneficiaries are actually being cross-walked to a different PDP. If the latter, CMS will perform the following additional steps:

- Determine if the PDP had a premium below the LIS regional benchmark and a basic benefit in the current year.
  - If it does not, then the PDP will be carved out of reassignment (i.e. not considered "terminating" for purposes of reassignment), and all beneficiaries will be cross-walked.
  - If it does, CMS will determine whether the PDP to which beneficiaries are cross-walked qualify as a "Gaining" PDP per section 40.1.5.G.
    - If so, the beneficiaries will not be included in reassignment, and all beneficiaries will be cross-walked, since the plan to which they are being cross-walked will have no premium for those with 100% premium liability.
    - If not, beneficiaries who meet the criteria for reassignment due to premium increase in section 40.1.5.A above will be reassigned (to ensure they have no new premium liability the following year); the remaining beneficiaries will be cross-walked.

CMS account managers will contact losing plans in September to confirm the plan is aware it will lose beneficiaries due to reassignment. Plans that are uncertain about whether they will lose to reassignment should contact their CMS account manager to confirm.

Volunteering for "De Minimis"

As noted above, per section 1860D-14(a)(5) of the Social Security Act, a PDP or Medicare Advantage with Prescription Drug (MA-PD) plan may volunteer to waive the portion of the monthly adjusted basic beneficiary premium that is up to a de minimis amount above the LIS benchmark for a subsidy eligible individual. The de minimis amount may not be waived from the enhanced portion of a Part D premium applicable to the enhanced benefit.

CMS will announce the de minimis amount in August, when the benchmarks are released. We will determine the de minimis amount taking into consideration the goal of minimizing reassignments without undue cost to the Medicare Trust Fund.

CMS will not reassign LIS members from plans that volunteer to waive the de minimis amount. However, for continuing Part D plans, we only reassign beneficiaries originally assigned to a zero-premium PDP that will have a new premium liability in the following year. We do not reassign beneficiaries from continuing MA plans, regardless of the level of the Part D premium. As a result, while any Part D plan that qualifies may volunteer to waive the de minimis premium, we anticipate that the only Part D plans that are likely to volunteer are those continuing PDPs that would otherwise lose beneficiaries to reassignment.

A Part D sponsor will volunteer to waive de minimis premium amount on a plan by plan basis. The Sponsor may opt to volunteer for one plan benefit package that qualifies and not another. For each plan benefit package for which a Sponsor volunteers, the Sponsor agrees to waive the de minimis premium amount for all LIS beneficiaries with 100% premium subsidy in that plan benefit package. This includes any member for any month in the contract year for which the individual is 100% premium subsidy eligible. The Part D sponsor will be responsible for identifying these members based on existing data already transmitted by CMS, and ensuring no premium is charged to them.

Plans with de minimis premiums must inform CMS of their intent to participate in the voluntary de minimis program within five business days after the de minimis amount is released. Specific dates will be provided when the de minimis amount is announced. Plans will inform CMS of their intention to participate through HPMS. A de minimis link will be available from the left navigation bar in HPMS under Plan Bids/Bid Submission/CY2011/Manage Plans. <u>All organization users with the bid download/upload access type associated with a contract number will have access to the de minimis page for qualifying plans under the contract number. The default value will be unchecked (i.e., "No") so a plan must select the checkbox to indicate that it wants to volunteer to participate.</u>

The HPMS screenshot will appear as follows:

A prescription drug plan (PDP) or Medicare Advantage Plan with Prescription Drug coverage (MA-PD) that offers basic Part D coverage may volunteer to waive the portion of the monthly adjusted basic beneficiary premium that is a de minimis amount above the low-income subsidy (LIS) benchmark for an LIS eligible individual. CMS will not reassign LIS members from PDPs that volunteer to waive the de minimis amount. (Please note: CMS does not reassign LIS beneficiaries from MA-PD plans that are renewing).

For plan year 2011, the de minimis amount will be $___.

To volunteer to waive the de minimis amount for LIS beneficiaries with 100% premium subsidy:

1. Select the contract number(s) for which you have access.
2. Select the checkbox next to each plan for which you volunteer to waive the de minimis amount.

Please Note: The checkbox will only be available for plans that have a Part D premium that is within the de minimis amount of the LIS benchmark in their region.

Plans will have until <date> to volunteer to participate in de minimis

C. Re-assignment Process

CMS will attempt to reassign beneficiaries within the same organization wherever possible. First, CMS will identify other qualified plans in the same region offered under the same contract number, or if that is not available, under a different contract number sponsored by the same parent organization. If the organization has more than one such plan in that region, CMS will randomly reassign beneficiaries among those plans. CMS will first attempt to identify a benchmark PDP within the same organization; only if none are available will it assign to a PDP within the same organization that volunteers to waive the de minimis amount above the benchmark.

If the organization does NOT offer another qualifying PDP, CMS will randomly reassign affected beneficiaries to other 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 (see section 40.1.4.C). CMS will not randomly reassign to de minimis plans.

Reassignment usually takes place in early October. CMS will send a preliminary file of reassignees to "gaining" and "losing" plans in mid-October. This file shall be used by plans for purposes of identifying beneficiaries who will be receiving CMS' blue reassignment letters; for "gaining" plans to obtain full name and address data; and for "losing" plans to identify the appropriate ANOC per section 40.1.5.E. The final confirmation will be received via TRR in late November.

Please note: beneficiaries are not always assigned to a "gaining" PDP that serves the same region as the "losing" PDP. CMS will use the beneficiary's state of residence to determine where the beneficiary needs to be reassigned. CMS determines state of residence first by checking if a state submitted the person on a recent state MMA file; if the person was not included on a recent state MMA file, CMS then uses the beneficiary address on its system. It is possible that, since originally assigned to a plan, a beneficiary's address had changed, so s/he must be reassigned to a new region. As a result, when reassignment is to another plan within the same organization, sponsors may not see all beneficiaries from the "losing" plan moved to the "gaining" plan. In addition, PDPs in regions with no "losing" plans may gain a few beneficiaries from reassignment.

Finally, "gaining" plans may receive reassignees that appear to reside outside the region (based on beneficiary address), but who are not. For these individuals, sponsors should follow the procedures in section 50.2.1.4.

CMS may conduct a second reassignment for LIS beneficiaries in non-renewing Medicare Advantage plans (see section 40.1.8 of Chapter 2 of the Medicare Advantage Manual). In this second reassignment, "gaining" PDP's will receive a second round of reassignees.

D. 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 1860D-14(c), 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), as well as a description of the right to coverage determination, exception, reconsideration, appeal, or grievance. The model CMS notice will be available on the following web page in the fall of each year:
http://www.cms.gov/LimitedIncomeandResources/LISNoticesMailings/list.asp#TopOfPage

E. Plan Communication to Affected Beneficiaries

"Losing" PDPs are responsible for sending an appropriate ANOC, as follows:

- If individuals are being reassigned within the same organization, the ANOC should be for the following year's plan, and include the Evidence of Coverage and LIS Rider.
- If the PDP is losing beneficiaries to a different PDP sponsoring organization, it may, at its discretion, use the alternate ANOC in Exhibit 30; it need not send the Evidence of Coverage or LIS Rider.
    - If it chooses to use the standard ANOC, it should use the version applicable to the plan in which the beneficiary is currently enrolled, and shall include the Evidence of Coverage and LIS Rider.

"Losing" PDPs should make their best effort to identify individuals who will be lost to reassignment for purposes of providing the appropriate ANOC. Plans may identify potential reassignees by identifying those that meet <u>both</u> of the following conditions:

Individuals initially assigned by CMS (enrollment source = A [auto-enrollment], C [facilitated enrollment] or H [reassignment]; or TRCs 117, 118, or 212A)

<u>and</u>

Individual has 100% premium subsidy in following year (per the TRR or monthly LIS history report)

Terminating PDPs should send a termination notice as instructed in the Call Letter.

Additionally, "losing" plans will be required to send a letter confirming disenrollment from the plan due to re-assignment within 10 calendar days from receiving disenrollment confirmation on a TRR (See Exhibit 10(b) for model letter).

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

"Gaining" PDPs do not need to send the 30-day Coordination of Benefits survey for new enrollees whether they are auto or facilitated enrolled; they only need to conduct the annual survey.

F. Requests for "Re-Enrollment" in the "Losing" Plan

CMS' notices to affected beneficiaries will instruct them to contact their current plan if they wish to remain with the plan for the following year. If a reassigned beneficiary contacts the plan and indicates that s/he wishes to remain enrolled despite incurring premium liability, **the plan must take a new enrollment election** in accordance with §40.1.1 – 40.1.3 and §40.2 f. For the new enrollment, use the actual application date, which should be no earlier than October 15 of the current year; an election type of "S" (Special Enrollment Period), and an effective date of January 1 of the following year.

As part of this enrollment, the plan must confirm and document the beneficiary's understanding of the financial liability s/he will incur by remaining with the plan for the following year. **However, DO NOT transmit these enrollment elections to CMS until a TRR is received confirming the beneficiary's disenrollment from the plan in late November.** If the "re-enrollment" transaction is sent in before disenrollment due to reassignment is confirmed, the transaction will be rejected as "beneficiary already enrolled." For beneficiaries re-enrolling in their current plan, the sponsor need not send a disenrollment confirmation letter, but must send the standard enrollment confirmation letter in section 40.4.

G. "Gaining" PDPs

PDPs that qualify for auto- and facilitated enrollment (see section 40.1.4.B) with effective dates starting January 1 of the following year will also qualify to receive those LIS beneficiaries reassigned as described above. Qualifying PDPs must meet the "Requirements Critical for Ensuring Effective Enrollment of Dual Eligible individuals" issued August 31, 2006. The only time CMS will reassign to a de minimis PDP is when a PDP sponsoring organization does not offer a benchmark PDP in the region, but does offer a de minimis PDP.

40.1.6 - Group Enrollment Mechanism for Employer/Union Sponsored PDPs

CMS will allow a PDP sponsor to accept enrollment requests into an employer or union sponsored PDP using a group enrollment process that includes providing CMS with any information it has on other insurance coverage for the purposes of coordination of benefits, as well as creditable

coverage history it has on each beneficiary group enrolled for purposes of assessing the late enrollment penalty.

It is the PDP sponsor's responsibility to ensure the group enrollment process meets all applicable PDP enrollment requirements. PDP sponsors must ensure that any contracts and/or 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 notification and materials to each beneficiary as follows:

- Beneficiaries participate in the group enrollment mechanism by receiving advance notice that the employer/union intends to enroll them for a prospective date in a PDP that the employer/union is offering; and
- That the beneficiary may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to employer/union benefits opting out would bring; and
- This notice must be provided by the PDP sponsor, 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 group sponsored PDP.
- Additionally, the notification materials provided must include a summary of benefits offered under the employer/union sponsored PDP, an explanation of how to get more information about the PDP, and an explanation on how to contact Medicare for information on other Part D options that might be available to the beneficiaries. Each individual must also receive the information contained on page 3 of Exhibit 1 of this guidance

The PDP sponsor 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 is the first day of the month prior to the effective date of the group enrollment for all mechanisms at all times. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems. For the purposes of providing notices and meeting other timeframe requirements, PDP sponsors will 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.

The employer or union must provide in the group enrollment file(s) all the information required for the PDP sponsor to submit a complete enrollment request transaction to CMS, including permanent residence information (refer to Appendix 2 for a complete list of the elements required for an enrollment transaction to be considered complete). Records must be maintained as outlined in §60.8 of this chapter.

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

CMS will allow sponsors 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 section 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 sponsor to provide the required data elements for the sponsor to process and submit an enrollment request to CMS.
- The SPAP must provide a notice to its members in advance of submitting the requests for a prospective date that explains that the SPAP is enrolling on their behalf, how the enrollment works with the SPAP and how individuals can decline such enrollment.

In return, PDPs that agree to accept enrollment requests from SPAPs in this format are required to process them like any other enrollment and in accordance with notification timeframes. Additionally, the sponsor must ensure the SPAP has met the above requirements prior to submission of the enrollment transaction to CMS. It is important for the PDP sponsor to work with the contact at the SPAP in the event that the plan encounters any problems processing the enrollment request in the format provided. Because the SPAP is the authorized representative of the beneficiary, the sponsor 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 the employer/union 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 for the AEP, the application date 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.

40.2 - Processing the Enrollment Request

If an enrollment request is completed during a face-to-face interview, the PDP sponsor 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/or enrollment in Part B. If the form is mailed or faxed to the PDP sponsor, or for on-line or other enrollment processes, the PDP sponsor 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 request. Regardless of whether or not the sponsor has reviewed the Medicare Identification card, the sponsor 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 the enrollment request complete. If the PDP sponsor receives an enrollment request that contains all these elements, the PDP sponsor must consider the enrollment request complete even if all other data elements on the enrollment request are not provided. If a PDP sponsor has received CMS approval for an

enrollment request mechanism that contains data elements in addition to those on the model paper enrollment form included in this guidance, the enrollment request must be considered complete even if those additional elements are not provided.

If a PDP sponsor 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 PDP sponsor must check available CMS systems (e.g. either the BEQ or 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 PDP sponsor has access to this information via available systems, the sponsor must not request 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 PDP sponsor must follow the procedures outlined in §40.2.2 in order to complete the enrollment request.

The following should also be considered when completing an enrollment:

A. Permanent Residence Information - The PDP sponsor must obtain the individual's permanent residence address to determine that he or she resides within the PDP plan's service area. If an individual puts a Post Office Box as his or her place of residence on the enrollment request, the PDP sponsor must consider the enrollment election 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 PDP sponsor should consult the State law in which the PDP sponsor operates and determine whether the enrollee is considered a resident of the State.

Individuals for whom the Batch Eligibility Query (BEQ) or MARx online query (M232 screen) reflects an incarcerated status reside outside of the service area and are, therefore, not eligible to enroll.

B. Entitlement Information – Following the procedures outlined in the CMS Plan Communications User Guide, PDP sponsors must verify Part D eligibility/Medicare entitlement by either the Batch Eligibility Query (BEQ) process or the MARx online query (M232 screen) or its equivalent for all enrollment requests except enrollment requests from a current enrollee of a PDP who is requesting enrollment into another PDP 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/or enrollment in Part B with their enrollment request. If the systems (BEQ or MARx on-line query) indicate that the individual is entitled to Medicare Part A and/or enrolled in Part B, then no further documentation of Medicare entitlement from the individual is needed.

When neither the BEQ, the MARx online query, nor MAPDIUI (Medicare Advantage Prescription Drug Interactive User Interface) beneficiary eligibility query shows Medicare eligibility for Part D, the PDP organization must consider the individual's Medicare ID card to be evidence of Medicare entitlement. When neither BEQ/MARx/MAPDIUI query

nor the Medicare ID card is available, the sponsor must consider an SSA award letter that shows Medicare entitlement (including start dates) as evidence of Medicare entitlement.

Please refer to §20 for more information about the relationship between Medicare A & B entitlement and the start of Part D eligibility.

If the PDP sponsor is not able to verify entitlement as described above, refer to §40.2.3 for additional procedures.

C. Effective Date of Coverage - The PDP sponsor must determine the effective date of enrollment as described in §30.4 for all enrollment requests. If the individual fills out an enrollment request in a face-to-face interview or through telephone enrollment, then the PDP sponsor 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 PDP sponsor to confirm the actual effective date of enrollment. The PDP sponsor must notify the member of the effective date of enrollment prior to the effective date (refer to §40.4 for more information and a description of exceptions to this rule).

If an individual submits an enrollment request with an unallowable effective date, or if the PDP sponsor allowed the individual to select an unallowable effective date, the PDP sponsor must notify the individual in a timely manner and explain that the enrollment must be processed with a different (allowable) effective date of enrollment. The organization should resolve the issue with the individual as to the correct effective date, and the notification must be documented. If the individual refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the enrollment according to the procedures outlined in §60.1.

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

For auto/facilitated enrollments, refer to section §40.1.4 of this guidance for more information.

D. Health Related Information - PDP sponsors may not ask health screening questions during the enrollment process.

E. Statement of Understanding and Release of Information - The PDP sponsor must include the information contained in **Exhibit 1** on page 3 under the heading "Please read and sign below" in all of its enrollment request vehicles.

F. Signature and Date on Paper Enrollment Forms - When a paper enrollment form is used, the individual must sign the enrollment form. If the individual is unable to sign the form, a legal representative must sign the enrollment form (refer to §40.2.1 for more information). If a legal representative signs the form for the individual, then he or she

must attest on the form that he or she has the authority under State law to effect the enrollment request on behalf of the individual and that a copy of the proof of other authorization required by State law that empowers the individual to effect an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Acceptable documentation includes items such as court-appointed legal guardianship or durable power of attorney.

The individual and/or legal representative should also write the date he/she signed the enrollment request; however, if he/she inadvertently fails to include the date on a paper enrollment form, or if an alternate enrollment mechanism is used, then the date of receipt that the PDP sponsor notes on the enrollment request will serve as the "signature date" of the request.

If a paper enrollment form is submitted and the signature is not included, the PDP sponsor 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).

When an enrollment request mechanism other than paper is used, the individual or his or her legal representative must complete the enrollment mechanism process, including the attestation of legal representative status as described above. A pen-and-ink signature is not required.

G. Other Signatures - If the PDP sponsor representative helps the individual fill out the enrollment request, then the PDP sponsor representative must clearly indicate his/her name on the enrollment form and indicate his/her relationship to the individual. However, the PDP sponsor 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 PDP sponsor 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 PDP sponsor receives an enrollment request that was completed more than 30 calendar days prior to the PDP sponsor's receipt of the request, the PDP sponsor 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 PDP sponsor must date as received all enrollment requests as soon as they are initially received. The application date is the date the enrollment request is initially received by the PDP sponsor, except for requests submitted via the CMS On-line Enrollment Center, requests made into employer or union-

sponsored plans, and auto or facilitated enrollments (refer to §10 for definitions of "receipt of enrollment request," "completed enrollment request" and "application date"). If the request received is incomplete, follow the instructions provided in section 40.2.2 below.

Part D plans must use the application date in the appropriate field when submitting enrollment transactions to CMS. Appendix 3 of this guidance provides a summary of application dates for CMS enrollment transactions.

J. Correction of Information - The PDP sponsor may find that it must make corrections to an individual's enrollment request. For example, an individual may have made an error in writing his or her telephone number or may have transposed a digit in his or her date of birth. The PDP sponsor should make this type of correction to the enrollment request (e.g. the enrollment form) when necessary, and the individual making those corrections should place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, or an electronic record of a similar nature, may be used by the PDP sponsor (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 PDP sponsor having to co-sign the enrollment form.

K. Sending the Enrollment to CMS – For all complete enrollment requests, the PDP sponsor must transmit the appropriate enrollment transaction to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §30.4 within the required time frames. Processes for submitting transactions are provided in CMS systems guidance.

L. Premium Payment and Withhold options

At minimum, PDP sponsors 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/RRB 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 a credit card.

The enrollment mechanism must advise the individual that if s/he does not select a premium payment option, the default action will be direct bill.

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

On the enrollment mechanism, PDP sponsors must also include in this section a statement that advises 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 and 1b to reflect the required options.

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

M. U.S. Citizenship or Lawful Presence Information – PDP sponsors must use the CMS Batch Eligibility Query (BEQ), (individual or batch submission) or, via on-line access, the MARx M232 screen, to verify eligibility on the basis of incarceration status or unlawful presence status. An exception to this are enrollment requests from a current enrollee of a PDP who is requesting enrollment into another PDP offered by the same parent organization with no break in coverage (i.e., "switching plans").

Individuals are not required to provide evidence of U.S. citizenship or lawful presence status with the enrollment request, nor are PDP sponsors permitted to request such information or documentation. The systems (BEQ or MARx online query) will indicate the lawful presence status of a non-U.S. citizen, including the start and, if applicable, the end date of the unlawful presence status of the individual.

CMS eligibility queries will only reflect data for the existence of an unlawful presence status. When neither the BEQ nor the MARx online query shows any indication of unlawful presence in the U.S., the PDP sponsor must treat the lack of information as confirmation of evidence of U.S. citizenship or lawful presence status.

When either the BEQ or the MARx online query shows an indication of unlawful presence in the U.S. and the organization receives documentation of lawful presence from the applicant, the plan cannot use this documentation to establish eligibility. If the PDP sponsor is provided evidence of lawful presence by the applicant in the form of a document from the Department of Homeland Security or SSA and neither the BEQ nor the MARx online query reflects this lawful presence status, the organization should refer the applicant to SSA to request that SSA update its records.

40.2.1 - Who May Complete an Enrollment Request

A Medicare beneficiary is generally the only individual who may execute a valid request for enrollment in, or disenrollment request from, a PDP. 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 effect a Part D enrollment or disenrollment request for Medicare beneficiaries. Persons authorized under State law may include 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 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, PDP sponsors should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

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

1) Attest that he or she has the authority under State law to do so;
2) Attest that proof of authorization, if any, required by State law that empowers the individual to effectuate an enrollment or disenrollment request on behalf of the individual is available upon request by CMS. Part D sponsors cannot require such documentation as a condition of enrollment or disenrollment; and
3) Provide contact information.

The sponsor 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 enrollment form (Exhibit 1).

If a sponsor 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 sponsor 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 PDP sponsor 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.

Representative payee status, as designated by SSA, is not necessarily sufficient to enroll or disenroll a Medicare beneficiary. Where PDP sponsors are aware that an individual has a representative payee designated by SSA to handle the individual's finances, PDP sponsors 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.

40.2.2 - When the Enrollment Request Is Incomplete

When the enrollment request is incomplete, the PDP sponsor must document its efforts to obtain the missing information or documentation needed to complete the enrollment request. The sponsor must make this determination and notify the individual within 10 calendar days of the receipt of the request that additional documentation is needed for the enrollment request, unless the required but missing information can be obtained via CMS systems.

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 IEP enrollment requests received prior to the month of entitlement to Part A or enrollment in Part B, additional documentation to make the request complete must be received during the first three months of the IEP, or within 21 calendar days of the request for additional information (whichever is later). For incomplete IEP enrollment requests received during the month of entitlement to Part A or 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 elections, 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 IEP for Part D begins on January 1, 2011 and ends on July 31, 2011. She submits an incomplete IEP enrollment request on January 15, 2011, and the sponsor 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 IEP for Part D begins on March 1, 2011 and ends on September 30, 2011. She submits an incomplete ICEP enrollment request on July 5, 2011, and the sponsor 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 an incomplete enrollment request is received near the end of 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). PDP sponsors 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 request complete is not received within the timeframe above, the organization must deny the enrollment request using the procedures outlined in §40.2.3.

Requesting Information from the Applicant - To obtain information to complete the enrollment, the PDP sponsor must contact the individual to obtain the information within 10 calendar days of receipt of the enrollment request (see Exhibit 3). If the contact is made orally (by phone), the PDP sponsor must document the contact and retain the documentation in its records. While CMS has provided a model notice, we would encourage plans to obtain information by the most expedient means available. The PDP sponsor must explain to the individual that if the information is not received within the timeframes described above, the enrollment will be denied. If the PDP sponsor denies the enrollment request, the sponsor must provide the individual with a notice of denial of enrollment (see Exhibit 6).

If all documentation is received within allowable time frames and the enrollment request is complete, the PDP sponsor must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must provide the individual with the information described in §40.4

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), a PDP sponsor may consider an enrollment request complete if there are premium amounts due to the sponsor from a prior enrollment, even if the sponsor has a policy to consider such enrollment requests incomplete.

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

40.2.3 - PDP Sponsor Denial of Enrollment

For enrollment requests that do not require additional information from the applicant, a PDP sponsor 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 PDP plan (e.g. individual not having a valid enrollment period to elect a plan). . For incomplete enrollment request that require information from the applicant and for which the applicant fails to provide the information within the required time frame, an a PDP sponsor must deny the enrollment within 10 calendar days of the expiration of the time frames described in §40.2.2.

PDP sponsor denials occur **before** the organization has transmitted the enrollment to CMS. For example, it may be obvious that the individual is not eligible to elect the plan due to place of residence. This “up-front” denial determination must be within 10 calendar days from the date of receipt of an enrollment request.

Notice Requirement - The organization must provide a notice of denial to the individual that includes an explanation of the reason for the denial (see Exhibit 6). This notice must be provided within 10 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:

- A PDP sponsor receives an AEP enrollment request from an individual on December 1st and determines on that same day that the individual is ineligible due to place of residence. The organization must provide the notice of denial within 10 calendar days from December

1st.

- A PDP sponsor 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 sponsor should send a notice of denial within ten calendar days from January 7.

- A PDP sponsor receives an AEP enrollment request on December 1st from an individual, identifies the enrollment request as incomplete, and on December 2 notifies the individual of the need for additional information. The beneficiary does not submit the information by December 23 (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 23.

40.3 - Transmission of Enrollments to CMS

For all enrollment requests effective January 1, 2008, and after that the organization is not denying per the requirements in §40.2.3, the PDP sponsor must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the PDP sponsor 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." All enrollment requests must be processed in chronological order by date of receipt of the enrollment request

PDP sponsors are encouraged to submit transactions on a flow basis and as early as possible to resolve the many data issues that arise from late submissions. However, if the organization misses the cutoff date, it must still submit the transactions within the required 7-day time frame.

NOTE: The 7-day requirement to submit the transaction does not delay the effective date of the individual's enrollment in the PDP, i.e., the effective date must be established according to the procedures outlined in §30.4.

More detail on how PDP sponsors 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 a PDP sponsor must provide to the enrolling individual must be provided prior to the effective date of enrollment. However, some information will be provided 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 (section 30), the PDP sponsor must provide required notices in response to information received by CMS on the TRR that provides the earliest notification. Sponsors 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. Sponsors choosing to utilize the BCSS for certain required beneficiary notifications must do so consistently.

The PDP sponsor may provide the required notices described in §§40.4.1 and 40.4.2 in a single ("combination") notice (see Exhibit 2b). The combination notice takes the place of separate acknowledgement and confirmation notices and, as such, requires expedited issuance. To use the combination notice, the sponsor must be able to provide this notice within 7 calendar days of availability of the TRR. Additionally, when following this option to use the combination notice, if the PDP sponsor 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 sponsor still must ensure that the beneficiary has the information required in §40.4.1 within these 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 sponsor 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 sponsor 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;
- The member will be responsible for paying the sponsor 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 Enrollment

Prior to the effective date of enrollment, the PDP sponsor must provide the member with all the necessary information about being a Medicare member of the PDP, including the PDP rules, and the member's rights and responsibilities (an exception to this requirement is described in §40.4.2.). In addition, the PDP sponsor must provide the following to the individual:

- For paper enrollment requests, a copy of the completed 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 enrollment request providing the expected effective date of enrollment (see Exhibit 2). This notice must be sent no later than 10 calendar days after receipt of the completed enrollment request; and

- Proof of health insurance coverage so that he/she may begin using the 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–CMS' marketing guidelines. The proof of coverage provided may be in the form of member ID cards, the enrollment form, and/or a notice to the member (refer to Exhibit 2, which is a model letter with optional language that would allow the member to use the letter as proof of 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 any other mechanism defined and allowed by CMS, the PDP sponsor 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; (including general information about the low income subsidy).

- The prospective member's consent to the disclosure and exchange of necessary information between the PDP sponsor and CMS.

- The potential for member liability if it is found that the member is not eligible for Part D at the time coverage begins and the member has used PDP 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 PDP sponsor has not yet provided the ID card).

Requirements for providing information to individuals enrolled via the auto-enrollment and facilitated enrollment processes are outlined §40.1.4.

40.4.2 - After the Effective Date of Coverage

CMS recognizes that for some enrollment requests, the PDP sponsor will be unable to provide the materials to the individual, including notification of the effective date, prior to the effective date, as generally required in §30.4.1. These cases will usually occur only when an enrollment request is received by the PDP sponsor in the last few days of a month, and the effective date is the first of the upcoming month. In these cases, the PDP sponsor still must provide the individual all materials described above no later than 10 calendar days after receipt of the enrollment request. In these cases, the PDP sponsor 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, information to access benefits and explain the PDP 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 PDP sponsor receives a TRR from CMS indicating whether the individual's enrollment has been accepted or rejected, the PDP sponsor must notify the individual of CMS' acceptance or rejection of the enrollment within 10 calendar days of the availability of the TRR that contains the earliest notification of the acceptance/rejection (see Exhibits 4 and 7). 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 no Medicare Part A and/or no Medicare Part B is received but the PDP sponsor has evidence to the contrary. In this case, the PDP sponsor must request a retroactive enrollment correction 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 enrollment correction due to its determination that the individual indeed does not have Medicare Part A or Part B, the PDP sponsor must reject the enrollment and must notify the individual of the rejection within 10 calendar days after CMS' (or its designee's) determination. Retroactive enrollments are covered in more detail in §60.3.

If a PDP sponsor rejects an enrollment request and later receives additional information from the individual substantiating his/her eligibility, the PDP sponsor 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 §60.3 for more information regarding retroactive enrollments.

40.5 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive action may be necessary (refer to §§50.3 and 50.5 for more information). 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 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 a PDP sponsor or CMS determines at a later date that an incorrect permanent address was provided at the time of enrollment and the actual permanent address is outside the PDP's service area.

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 individual, or his/her legal representative, did not intend to enroll in the PDP. If there is evidence that the individual did not intend to enroll in the PDP, the PDP sponsor should submit a retroactive

disenrollment request to CMS (or the CMS Retroactive Processing Contractor). Evidence of lack of intent to enroll by the individual may include:

- An enrollment request signed by the individual when a legal representative should be signing;
- Request by the individual for cancellation of enrollment before the effective date (refer to §60.1.1 for procedures for processing cancellations).

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 a PDP.

50 - Disenrollment Procedures
42 CFR 423.36 & 423.44

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

All notice requirements are summarized in **Appendix 1.** The PDP sponsor must provide disenrollment notices in response to transaction replies received from CMS based upon the TRR.

NOTE: It is not necessary for a Part D sponsor 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 PDP 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 an Individual

A member may request disenrollment from a PDP only during one of the periods outlined in §§30.2 and 30.3. 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 PDP sponsor, or through the member's employer/union group, where applicable;
3. Submitting a request via Internet to the PDP sponsor (if the PDP sponsor offers such an option);
4. Calling 1-800-MEDICARE.

If a member verbally requests disenrollment from the PDP, the PDP sponsor must instruct the member to make the request via one of the methods outlined above. The PDP sponsor may send a disenrollment form to the member upon request (see Exhibits 8 and 9).

The disenrollment request must be dated when it is received by the PDP sponsor.

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 PDP sponsor or CMS; and
3. Provide contact information.

50.1.1 – Requests Submitted via Internet

The PDP sponsor has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The PDP sponsor must, at a minimum, comply with the CMS security policies - found at http://www.hhs.gov/informationsecurity/.

The PDP sponsor 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 also require PDP sponsors 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 sponsor is complying with the required encryption, authentication, and identification requirements. The effective date of the request is determined by the election period in which the valid request was received by the sponsor. The election period is determined by the date the request is received at the site designated by the sponsor.

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

CMS reserves the right to audit the PDP sponsor to ascertain whether it is in compliance with the security policy.

50.1.2 – Request Signature and Date

When requesting voluntary disenrollment by submitting 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 the request is not signed, see section 50.4.2 for information to complete the disenrollment request.

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 PDP sponsor 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 sponsor may verify with the individual 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 a valid request to disenroll was received by the PDP organization will determine the effective date of the disenrollment request; refer to §30.5 for information regarding disenrollment effective dates.

With the exception of some SEPs and when periods overlap, individuals may not choose the effective date of disenrollment. Instead, the PDP sponsor is responsible for assigning the appropriate effective date based on the enrollment period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the PDP sponsor staff are responsible for ensuring that a beneficiary does not attempt to choose an effective date that is not allowed under the requirements outlined in §30.5.

If an individual submits a disenrollment request with an unallowable effective date, the PDP sponsor must contact 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 contact must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary may cancel the disenrollment according to the procedures outlined in §60.2.2 prior to the effective date.

50.1.4 – PDP Sponsor Denial of Voluntary Disenrollment Request

If the PDP sponsor receives a disenrollment request that it must deny, the PDP sponsor must notify the enrollee within 10 calendar days of the receipt of the request, and must include the reason for the denial (see Exhibit 11).

A PDP sponsor may deny a voluntary request for disenrollment only when:

1. The request was made outside of an allowable period as described in §20 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 §30.2.1).
3. The request was incomplete and the required information) is not provided within the required time frame.

50.1.5 – Notice Requirements

After the member submits a disenrollment request, the PDP sponsor must provide the individual a disenrollment notice within ten (10) calendar days of the date the request to disenroll was received (see Exhibit 10). The disenrollment notice must include an explanation that the individual remains enrolled in the PDP until the effective date of the disenrollment. For these types of disenrollments (i.e., disenrollments in which the individual has disenrolled directly through the PDP sponsor, PDP sponsors are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment via the TRR.

Since Medicare beneficiaries have the option of disenrolling through 1-800-MEDICARE, or by enrolling in another Part D plan, the PDP sponsor will not always receive a request for disenrollment directly from the individual but will instead learn of the disenrollment through the TRR. If the PDP sponsor learns of the disenrollment from the TRR (as opposed to through the receipt of a request from the enrollee), the PDP sponsor must send a notice of confirmation of the disenrollment to the individual within 10 calendar days of the availability of the TRR (see Exhibit 10a). The disenrollment confirmation notice is not required for automatic disenrollments resulting from an individual's enrollment in a PBP within the same Part D contract.

For denials of voluntary disenrollment requests as described in §50.1.4, the denial notice must be sent within 10 calendar days of the date the disenrollment request was received. It must also include the reason for denial (see **Exhibit 11**).

50.2 - Required Involuntary Disenrollment

A PDP organization must disenroll an individual from a PDP in the following cases.

1. A change in residence (including incarceration) makes the individual ineligible to be an enrollee of the PDP (§50.2.1)
2. The individual loses entitlement to Medicare (§50.2.2.);
3. The individual dies (§50.2.3);
4. The PDP contract is terminated, the PDP sponsor discontinues offering a PDP or reduces the plan service area such that the individual no longer resides in the plan service area (§50.2.4);
5. The individual materially misrepresents information to the PDP sponsor regarding reimbursement for third-party coverage (§50.2.5) ; or
6. The member fails to pay his/her Part D-IRMAA to the government and CMS notifies the PDP to effectuate the disenrollment (§50.2.6).
7. The member is not lawfully present in the United States (§50.2.7).

Incarceration – An individual who is incarcerated resides outside the plan service area, even if the correctional facility is located within the plan service area (see §10 for definition of "incarcerated").

Notice Requirements - Disenrollment notices must be sent when:

- The individual has a change in residence and is determined to be out of the plan's service area;
- CMS disenrolls the individual due to incarceration;
- The individual loses eligibility for enrollment due to contract termination or service area reduction by the PDP sponsor;
- The individual materially misrepresents information to the PDP sponsor regarding reimbursement for third-party coverage; or
- CMS disenrolls the individual for non-payment of Part D-IRMAA.

For disenrollments effectuated by the PDP sponsor, all disenrollment notices must:

1. Advise the member that the sponsor 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 sponsor's grievance procedures. (This explanation is not required if the disenrollment is a result of plan termination or service area reduction, since a hearing would not be appropriate for that type of disenrollment. There are different notice requirements for terminations and area reductions, which are provided in separate instructions to sponsors.)

For disenrollments effectuated by CMS due to incarceration or nonpayment of Part D-IRMAA, the disenrollment notice must advise the member that the plan has disenrolled him or her, why such action is occurring and be mailed within ten (10) calendar days of receiving the disenrollment TRR from CMS.

Plans are strongly encouraged, but not required, to send notices for certain CMS-effectuated disenrollments, including:

- Death (Exhibit 13);
- Loss of entitlement (Exhibit 14); and
- Unlawful presence in the United States (Exhibit 37).

For plans that provide disenrollment notices for these situations, the disenrollment notices should advise the member that the plan has disenrolled him or her and why such action is occurring. Plans are encouraged to mail these notices within ten (10) calendar days of receiving the disenrollment TRR from CMS.

50.2.1 - Sponsor Receives Notification of Possible Residence Change

The Part D sponsor must disenroll an individual when an individual (or legal representative) notifies the PDP that he or she has moved and no longer resides in the service area of a PDP. The sponsor must retain documentation of the permanent change of address and disenroll the individual. If the sponsor offers another PDP in the region into which the beneficiary has moved, the sponsor may use this opportunity to inform the beneficiary of its other PDP product(s).

If the PDP sponsor learns of a beneficiary address change that is outside the PDP service area from either CMS (i.e. a state and county code change on the TRR) or from the U.S. Postal Service (USPS), it must follow the "Researching and Acting on a Change of Address" procedures outlined below.

An SEP, as defined in §20.3.1, 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 Part D sponsor must disenroll a member if:

1. He/she permanently moves out of the service area;

2. The member's temporary absence from the service area exceeds 12 consecutive months;

3. The member is incarcerated and, therefore, resides out of area for the duration of the incarceration.

50.2.1.2 – Effective Date of Disenrollment

Disenrollment is effective on the first of the month following the month in which the individual (or his or her legal representative) notifies the PDP sponsor that he or she 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 or she will be moving.

In the case of incarcerated individuals, CMS will involuntarily disenroll individuals who are incarcerated based on data CMS receives from SSA. CMS will report the disenrollments to the organization via the daily TRR using a specific Transaction Reply Code (TRC). For all such disenrollments, the effective date of disenrollment will be the first of the month after the incarceration start date.

Sponsors may receive notification of the individual's possible incarceration status via another source. In this situation, the PDP sponsor needs to investigate and, following processes in §50.2.1.3, determine if the member resides in the plan's service area and, if appropriate, involuntarily disenroll the member. *If the incarceration information is received from a public entity or other source with direct access to confirmed incarceration data, such as a penal facility, state Medicaid agency or other state or federal agency, additional investigation is not necessary.* Disenrollment is effective the first of the month following the sponsor's confirmation of a current incarceration. The PDP sponsor is required to send notification of the disenrollment to the member.

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 sponsor can submit this request to CMS (or its designee) for consideration of retroactive action.

Disenrollment as a result of receiving information from either CMS or the U.S. Post Office that the individual has not confirmed will be effective the first day of the calendar month after 12 months have passed.

50.2.1.3 - Researching and Acting on a Change of Address

Within ten (10) calendar days of receiving information from either CMS or the USPS that a beneficiary may no longer reside in the service area, a PDP sponsor must make an attempt to contact the member to determine the beneficiary's permanent residence and must document its efforts in doing so (may use Exhibit 33 if contacting the member in writing). The requirement to attempt to contact the member does not apply to a prospective enrollment for which the sponsor receives either transaction reply code 011 (Enrollment Accepted) or 100 (PBP Change Accepted as Submitted) accompanied by transaction reply code 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. The PDP sponsor may accept either written or verbal confirmation that an individual has moved out of the service area, as long as the PDP sponsor applies the policy consistently among all members.

In the case of individuals for which the plan learns of possible incarceration status from a source other than CMS, the PDP sponsor must confirm the individual's out of area (i.e., incarcerated) status. Confirmation may include contacting the individual or other sources to determine confirmation of incarceration and incarceration start and end dates, if applicable. *As described in §50.2.1.2, additional investigation is not necessary if the incarceration information is received from a public entity or other source with direct access to confirmed incarceration data.* PDP sponsors may disregard past periods of incarceration that have been served to completion and have not already been addressed by a plan or CMS.

If a sponsor confirms an individual's current incarceration status but does not obtain the start date of the current incarceration, the sponsor must disenroll the individual prospectively for the first of the month following the date on which the current incarceration was confirmed. If a sponsor confirms an individual's current incarceration status as well as the start date of the current incarceration, the sponsor 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 sponsor must submit the retroactive disenrollment request to the CMS Retroactive Processing Contractor (see §60.4).

If the PDP sponsor does not receive confirmation from the member (or his or her legal representative) within a 12 month period, the PDP sponsor must initiate disenrollment. The 12 month period will begin on the date the change of address is identified (e.g. through the TRR or forward address notification from the USPS).

When researching changes of address, CMS encourages sponsors to utilize resources available to them, including any CMS systems interfaces, internet search tools, address information from provider claims, etc.

50.2.1.4 – Special Procedures for Auto and Facilitated Enrollees Whose Address Is Outside the PDP Region

CMS assigns most beneficiaries based on the State Medicaid Agency that reports the individual as dual eligible, even if that state is different than that in the address on CMS' systems. In addition, beneficiaries may move after auto/facilitated enrollment occurs. If the PDP sponsor discovers that an individual whom CMS had auto/facilitated enrolled or reassigned has an address outside of the PDP sponsor's region (e.g. via a state and county code change on the TRR or the USPS), the PDP sponsor must make an attempt to determine the beneficiary's permanent residence and must document its efforts in doing so. The PDP sponsor may accept either written or verbal confirmation that an individual has moved out of the service area, as long as the PDP sponsor applies the policy consistently among all members.

If the sponsor confirms **the move is temporary**, the PDP sponsor must retain the individual as a member.

If the sponsor confirms **the move is permanent** and has a PDP in the new region that offers a basic benefit package (i.e. other than enhanced) with a premium at or below the low-income premium subsidy amount for that region, the PDP organization may submit an enrollment transaction to enroll the beneficiary in that PDP prospectively (See Exhibit 27). Sponsors must use the first day of the month prior to the enrollment effective date as the application date and an enrollment source code data value of "B." In this event, no enrollment form or other election is necessary. However, an enrollment form is necessary if the beneficiary chooses to enroll into another type of plan (e.g. enhanced) in the new region.

If the sponsor confirms **the move is permanent** and does not have a PDP in the new region that offers a basic benefit package with a premium at or below the low-income premium subsidy amount for that region, the PDP sponsor must inform the beneficiary that s/he must enroll in a PDP that serves the area where s/he now resides. The Sponsor must disenroll the beneficiary, effective the first of following month (see Exhibit 28).

If the sponsor is unable to contact the auto/facilitated enrolled beneficiary, or receives no response, the PDP sponsor must not disenroll the beneficiary. This includes situations in which the beneficiary's address is listed as a P.O. Box.

50.2.1.5 - 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 sponsor as undeliverable.

> Note: For auto and facilitated enrollees, CMS provides PDP sponsors with mailing addresses as maintained in CMS systems. These addresses are not always current, and in cases where the beneficiary has a representative payee, the address of the payee will be the address of record in CMS systems.

In the event that any member materials are returned as undeliverable, the PDP sponsor 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 sponsor receives documented proof from the USPS of a beneficiary change that is outside of the PDP region or mail is returned without a forwarding address, follow the procedures outlined in § 50.2.1.3.
3. If the beneficiary uses his or her drug coverage at a pharmacy in the plan's network, the sponsor may choose to follow up with the pharmacy to obtain the member's current address.
4. If the sponsor 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.

A PDP sponsor is expected to continue to mail materials to the member's address of record. 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 communications to that same address, as a forwarding address may become available at a later date. Additionally, CMS encourages the PDP sponsor to continue to research addresses as described in the "Researching and acting on change of address" above.

50.2.1.6 – Notice Requirements

1. **Part D sponsor notified of out-of-area permanent move -** When the sponsor receives notice of a permanent change in address from the individual, 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 ten (10) calendar days of the PDP sponsor's learning of the permanent move.

    In the case of incarcerated individuals disenrolled by CMS, we will report the disenrollments to the sponsor via the daily TRR using a specific TRC. The Part D sponsor must send each affected individual a written notice of the disenrollment within ten (10) calendar days of receipt of the TRR indicating disenrollment due to incarceration.

2. **Out of area for 12 months -** When the individual has been out of the service area for 12 months after the date the sponsor learned of the change in address from either CMS or the USPS and the sponsor has not be able to obtain confirmation, the sponsor must provide

notification of the upcoming disenrollment to the individual. Sponsors are encouraged to follow up with members and to issue interim notices prior to the expiration of the 12 month period.

The notice of disenrollment must be provided within the first ten calendar days of the 12th month. The notice should advise the member to notify the PDP sponsor as soon as possible if the information is incorrect. The transaction to CMS must be sent within 3 business days following the disenrollment effective date.

CMS strongly encourages that sponsors send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use plan services.

50.2.2 – Loss of Eligibility for Part D

An individual who is no longer entitled to either Medicare Part A and/or Part B benefits may not remain enrolled in a PDP. The sponsor will be notified by CMS that part D eligibility has ended. CMS will make the disenrollment effective the first day of the month following the last month of Part D eligibility.

Notice Requirements – Notice must 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 §60.2.1.

50.2.3 - Death

CMS will disenroll an individual from a PDP sponsor upon his/her death and CMS will notify the Part D sponsor that the individual has died. This disenrollment is effective the first day of the calendar month following the month of death. Sponsors 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, sponsors must submit the enrollment only when the date of death is equal to or greater than the effective date. In the anticipation at official notification from CMS via the TRR, the sponsor may, at its discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices.

Notice Requirements - Following the receipt of a CMS notification (via TRR) of disenrollment due to death, a notice must 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. The sponsor must send this notice within 10 days of the notification via the TRR. In cases of erroneous disenrollment and notification, refer to §60.2.1.

50.2.4 - Terminations/Nonrenewals

The PDP sponsor must disenroll an individual from a PDP if the PDP contract is terminated, the PDP sponsor discontinues offering the PDP or the PDP sponsor reduces the plan service area such that the individual no longer resides in the plan service area.

An individual who is disenrolled under these provisions has an SEP, as described in §30.4.3, to enroll in a different Part D plan.

Notice Requirements - The PDP sponsor must give each affected individual a written notice of the effective date of the termination, and include a description of alternatives for obtaining benefits under the Medicare program. CMS will provide further guidance to affected sponsors, as required by 42 CFR 423.507 - 423.509.

50.2.5 - Material Misrepresentation Regarding Third-Party Reimbursement

If a PDP enrollee intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires that the individual be disenrolled from the PDP. Involuntary disenrollment for this reason requires CMS approval. The PDP sponsor must submit any information it has regarding the claim of material misrepresentation to its CMS account manager for review. Disenrollment for material misrepresentation of this information is effective the first of the month following the month in which the enrollee is notified of the disenrollment or as CMS specifies.

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 Part D plan sponsor. CMS has established a 3-month initial grace period before individuals who fail to pay their Part D-IRMAA will be disenrolled from their Part D 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 must pay 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.

The Part D sponsor 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.

Notice Requirements – Part D plan sponsors 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 PDP for failure to pay Part D-IRMAA have the opportunity to ask CMS for reinstatement into the PDP from which they were disenrolled. CMS may reinstate enrollment, without interruption of coverage, if the individual demonstrates good cause and pays **in full** within three (3) calendar months of the disenrollment effective date:

- The Part D-IRMAA amounts that caused the disenrollment for nonpayment of Part D-IRMAA, and/or
- Any plan premium amounts owed at the time he or she was disenrolled. date

For more information on good cause, see §60.2.4.

50.2.7 – Unlawful Presence Status

The PDP sponsor cannot retain a member in a PDP if the member is not lawfully present in the United States. The sponsor may not request from a member any documentation of U.S. citizenship or alien status, as CMS provides the official status to the PDP sponsor. CMS will notify the organization (via TRR) that the individual is not lawfully present, and CMS will make the disenrollment effective the first day of the month following the notification by CMS.

Notice Requirements – Following the receipt of a CMS notification (via TRR) of the disenrollment due to unlawful presence, CMS strongly suggests that a notice be provided within ten (10) calendar days of receipt of the TRR (see Exhibit 37) so that the member is aware of the loss of coverage in the plan and any erroneous disenrollments can be corrected as soon as possible. See §60.2.1 for cases of possible erroneous disenrollment or notification.

50.3 - Optional Involuntary Disenrollments

A PDP sponsor may disenroll a member from a PDP 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 PDP (§50.3.3).

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

- Advises the member that the PDP sponsor 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 PDP sponsor'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

Part D sponsors may not disenroll a member who fails to pay plan cost sharing under this provision. However, a sponsor has two options when a member fails to pay plan premiums (this includes any Part D late enrollment penalty per Chapter 4 of the Prescription Drug Benefit Manual).

For each of its Part D plans (i.e. each PBP), the Part D sponsor must take action consistently among all members, i.e., a sponsor may have different policies among its different Part D plans, but it may not have different policies within a plan.

The Part D sponsor may:

1. Do nothing, i.e., allow the member to remain enrolled in the same PDP;

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

If a PDP sponsor 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 PDP sponsor 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, a PDP sponsor 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. A sponsor 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 sponsor chooses to disenroll the member, this action may only be accomplished by the sponsor after the sponsor makes a reasonable effort to collect the payment and notice has been provided to the member (as described below). If payment has not been received within a grace period, the individual will be disenrolled.

Sponsors **may not** 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 sponsor receives a TRR indicating that the member's request has been rejected. The sponsor 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.

Sponsors may not involuntarily disenroll any 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 sponsor 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 sponsor must notify the member of the premium owed and provide the appropriate grace period, as described below. Sponsors 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" and the member can demonstrate that SSA or 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.

> **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 or RRB 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 a plan 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 the Social Security Administration (SSA) or the Railroad Retirement Board (RRB), or between CMS and the sponsor. CMS recognizes that in some instances sponsors have not received premium amounts in their monthly CMS plan payment

for members who have elected Social Security withholding; however, sponsors cannot hold their members responsible for such issues, nor penalize them by attempting to disenroll them from their plan. Therefore, the sponsor **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 and the appropriate premium amount is deducted from the individual's SSA benefit check. However, due to a systems issue between CMS and SSA, 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.

CMS reminds sponsors that they **may not** disenroll a member or initiate the disenrollment process if the sponsor has been notified that a State Pharmaceutical Assistance Program (SPAP) or other payer intends to pay the entire Part D premium on behalf of an individual (Section 50.6 of Chapter 14 of the PDP Manual).

While the sponsor 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 is the first day of the month after the grace period ends. **The PDP sponsor 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 PDP sponsor may require the individual to pay any outstanding premiums owed to the PDP sponsor 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, 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.

Calculating the Grace Period

A PDP sponsor 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. sponsors 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** must be a minimum of 2 calendar months that begins on the 1st day of the month for which the premium is unpaid. The sponsor is required to have billed the member prior to the start of the grace period for the actual premium amount due, with such notice/bill specifying the due date for that amount. The sponsor must also provide the member with an opportunity to pay. For new enrollees, a PDP sponsor must wait until notified by CMS of the actual 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 sponsor receives notification from CMS as to the beneficiary's premium and notifies the individual of the amount due.
The grace period can then begin no earlier than the first day of the month on or after the due date.

PDP sponsors 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 - PDP sponsors 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 PDP sponsor) are not paid in full by the end of the grace period, the PDP sponsor may terminate the member's coverage.

As mentioned previously, the individual must be notified/billed of 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 PDP sponsor of the total premium due from the individual. Upon CMS notification, the PDP sponsor would bill the individual of the amount due, with a prospective due date.

Under this scenario, PDP sponsors 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, 2010. He did not pay this premium and on February 7th, the PDP sponsor 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, 2010.

Example B: Plan QRS has a 3 month grace period for premium payment. Plan member Mrs. Monsoon's premium was due on July 1, 2010. She did not pay this premium and on July 6th, the PDP sponsor 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, 2010.

The PDP sponsor must state that it requires the member to make full payment within the grace period, and pay all premiums falling due within that period, in its initial delinquency notice to the member if it chooses this policy.

Option 2 - PDP sponsors 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 sponsor may disenroll the member.

Sponsors 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, sponsors 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 two 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 sponsor 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 sponsor 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 PDP remains intact.

Notice Requirements - If it is the sponsor's policy to disenroll the member when a member has not paid plan premiums, the sponsor 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 sponsor may send interim notices after the initial notice. In addition to the notice requirements outlined in §60.3, 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, and the proposed effective date of this action; and

- Explain whether the sponsor 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.

If a notice is returned to the organization as undeliverable, the sponsor should immediately implement its procedure for researching a potential change of address (see sections 50.2.1.4 and 50.2.1.5) as well. The beneficiary may have moved out of the service area. If the sponsor confirms the permanent move such that a disenrollment date earlier than the end of the grace period is required, the sponsor must disenroll the beneficiary for the earlier disenrollment date.

If a member does not pay within the grace period, and the sponsor's policy is to disenroll the member, the sponsor must notify the member in writing providing the effective date of the member's disenrollment (see 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 sponsor 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, the sponsor must send final confirmation of disenrollment to the member within 10 calendar days of receiving the TRR (see Exhibit 21).

Optional Exception for Individuals who Qualify for Low Income Subsidy (LIS)

Sponsors have the **option** to retain individuals who qualify for the low income subsidy who fail to pay premiums even if the PDP sponsor has a policy to disenroll members for non-payment of premiums.

The PDP sponsor has the discretion to offer this option to individuals who qualify for the low income subsidy within each of its PDPs. If the PDP sponsor offers this option in one of its PDPs, it must apply the policy to all such individuals in that PDP.

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

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

50.3.2 - Disruptive Behavior

The PDP sponsor **may** request to disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the PDP substantially impairs the PDP sponsor's ability to arrange for or provide services to either that particular member or other members of the PDP. However, the PDP sponsor may only disenroll a member for disruptive behavior after it has met the requirements of this section and with CMS' approval. The PDP sponsor may not disenroll a member because he/she exercises the option to make treatment decisions with which the PDP sponsor disagrees. The PDP sponsor may not disenroll a member because he/she chooses not to

comply with any treatment regimen developed by the PDP sponsor or any health care professionals associated with the PDP sponsor.

Before requesting CMS' approval of disenrollment for disruptive behavior, the PDP sponsor 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 PDP sponsor must also inform the individual of his or her right to use the organization's grievance procedures.

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

- Of the disruptive behavior;
- Of the PDP sponsor's serious efforts to resolve the problem with the individual;
- Of the PDP sponsor'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 §423.44(d)(2)(iii) and (iv);
- That the PDP sponsor provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and
- That the PDP sponsor then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).

The PDP sponsor must submit to the CMS Regional Office:

- The above documentation;
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the PDP sponsor's ability to arrange for or provide services to the individual or other members of the PDP;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member.

The PDP sponsor may request that CMS consider prohibiting re-enrollment in the PDP (or PDPs) offered by the PDP sponsor in the service area.

The PDP sponsor'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. CMS will notify the PDP sponsor 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.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the PDP sponsor 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 PDP sponsor to delay the effective date of involuntary disenrollment to coordinate with an 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:

1. Advance notice to inform the member that the consequences of continued disruptive behavior will be disenrollment;

2. Notice of intent to request CMS' permission to disenroll the member; and

3. A planned action notice advising that CMS has approved the PDP sponsor's request.

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the PDP sponsor must provide the member with written notice describing the behavior it has identified as disruptive and how it has impacted the sponsor's ability to arrange for or provide services to the member or to other members of the 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 notice must also inform the individual of his or her right to use the organization's grievance procedures. The PDP sponsor 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 PDP sponsor must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the PDP sponsor's efforts, then the PDP sponsor 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. The PDP sponsor 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 a PDP sponsor to disenroll a member for disruptive behavior, the PDP sponsor 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 PDP sponsor may only provide the member with this required notice after CMS notifies the PDP sponsor of its approval of the request.

The PDP sponsor 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 PDP sponsor gives the member a written notice of the disenrollment, or as provided by CMS.

50.3.3 - Fraud and Abuse

A PDP sponsor may request to cancel the enrollment of a member who knowingly provides fraudulent information on the enrollment request that materially affects the member's eligibility to enroll in the plan. The sponsor 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 sponsor gives the member the written notice.

With such a disenrollment request, the sponsor must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

Notice Requirements - The PDP sponsor must give the member a written notice of the disenrollment that contains the information required at §50.3.

50.4 - Processing Disenrollments

Procedures for processing voluntary and involuntary disenrollments are described below.

50.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from an enrollee, the PDP sponsor is responsible for submitting disenrollment transactions to CMS in a timely, accurate fashion. Such transmissions for disenrollment requests must occur within 7 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The PDP sponsor must maintain a system for receiving, controlling, and processing voluntary disenrollments from the PDP sponsor. 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 PDP sponsor) to establish the date of receipt;

- Dating supporting documents for disenrollment requests as of the date they are received;

- Determining if the voluntary request is valid according to the requirements in §50.1 of this guidance;

- 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/union group (whichever applies);

- For disenrollment requests received by the PDP sponsor, to notify the member in writing within 10 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 10). PDP sponsors are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the TRR.

  When the voluntary disenrollment request is denied, the PDP sponsor must send written notice within 10 calendar days of the receipt of the request and include the reason for denial (see Exhibit 11).

- For all other voluntary disenrollments (i.e. voluntary disenrollments made by the beneficiary through 1-800-MEDICARE, by enrolling in another Medicare health plan or PDP or by consenting to passive enrollment into a Medicare-Medicaid demonstration plan, which the PDP sponsor would not learn of until receiving the TRR), the PDP sponsor must notify the member in writing to confirm the effective date of disenrollment within 10

calendar days of the availability of the TRR (see Exhibit 10a and 10c). 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), unless enrollment in the new PBP is the result of passive enrollment into a Medicare-Medicaid demonstration plan.

50.4.2 - When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete, the PDP sponsor 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 PDP sponsor may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

For AEP elections, 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 PDP sponsor is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The PDP sponsor must maintain a system for controlling and processing involuntary disenrollments from the PDP sponsor. 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 entitlement to Medicare Parts A and/or B, notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights, as provided in the applicable section of this guidance.

In addition, PDP sponsors must send confirmation of involuntary disenrollment to ensure the member discontinues use of PDP sponsor services after the disenrollment date.

50.5 - Disenrollments Not Legally Valid

When a disenrollment request that is not legally valid has been processed, a reinstatement action may be necessary (refer to §60.2 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 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.

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 PDP. If there is evidence that the member did not intend to disenroll from the PDP, the PDP sponsor 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 §60.1 for procedures for processing cancellations).

Discontinuation of payment of premiums 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 PDP sponsor, 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 Procedures for Employer /Union Sponsored Coverage Terminations

The employer/union establishes criteria for its retirees to participate in the employer/union sponsored PDP plan. These criteria are exclusive of the eligibility criteria for PDP 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. For this reason, when the contract between an employer or union group and a PDP sponsor is terminated, or the employer/union determines that a beneficiary is no longer eligible to participate in the employer/ union sponsored plan, the PDP sponsor has the option to follow one of two procedures to disenroll beneficiaries from the current employer/union sponsored PDP plan in which the individual is enrolled:

For both of these options, the PDP sponsor must ensure that the employer/union agrees to the following:

- The employer/union will provide the PDP sponsor with timely notice of contract termination or the ineligibility of the individual to participate in the employer/union group. Such notice must be prospective, not retroactive.

- The employer/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/union.

Option 1: Enroll the individual(s) in another PDP (i.e. individual plan) offered by the same PDP sponsor, unless the individual(s) make other choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area.

- Beneficiaries may elect another PDP or MA-PD offered by the employer or union, disenroll from the PDP, or join another PDP or MA-PD plan as an individual member, if he/she chooses, instead of electing the individual PDP offered by the same PDP sponsor.
    - If the beneficiary prefers not to be enrolled in the individual plan, he/she may contact the sponsor.
    - If the beneficiary would prefer enrolling in a different PDP or MA-PD plan as an individual member, he/she would submit an enrollment request to his/her newly chosen PDP or MA organization.

- If the individual takes no other action, he/she will become a member of the individual plan offered by the same PDP sponsor that offered the employer/union sponsored plan.

- **PDP Notice requirements** – The PDP sponsor (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.

Option 2: Disenroll individual(s) from the PDP sponsor following prospective notice.

- **PDP Notice requirements -** The PDP sponsor (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 group sponsored plan was a PDP, the individual must be advised that the disenrollment action means that 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 PDP sponsor 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 PDP sponsor's responsibility to ensure that the required elements of the disenrollment procedures described above are understood by the employer/union and are part of the agreement with each employer/union, including contract termination notification requirements.

50.6.1 – Group Disenrollment for Employer/Union Sponsored PDPs

CMS has provided, under our authority to waive or modify Part D requirements that hinder the design of, the offering of, or the enrollment in an employer or union sponsored Part D retiree plans, a process for group disenrollment from employer or union sponsored PDPs.

CMS will allow and employer or union group to disenroll its retirees from a PDP using a group disenrollment process.

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

- All beneficiaries must be notified that the group intends to disenroll them from the PDP that the group is offering; and
- This notice must be provided not less than 21 calendar days prior to the effective date of the beneficiary's disenrollment from the group sponsored PDP.

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

The employer or union group must have and provide all the information required for the PDP sponsor to submit a complete disenrollment request transaction to CMS as described in this and other CMS Part D systems guidance.

NOTE: This process applies to employer/union group direct contract PDP sponsors and MA Organizations and PDP sponsors that offer employer/union group-only plans.

60 - Post-Enrollment Activities

42 CFR 423.32 & 423.36

Post-enrollment activities occur after the PDP sponsor receives the enrollment request from the individual.

60.1 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment or disenrollment made by an individual. Unless otherwise directed by CMS, requests for cancellations can only be accepted prior to the effective date of the enrollment or disenrollment request. For employer or union groups, cancellations properly made to the employer or union prior to the effective date of the election being canceled are also acceptable.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary.

If a beneficiary verbally requests a cancellation of an enrollment or disenrollment request, the PDP sponsor must document the request and process the cancellation. PDP sponsors may request that the cancellation be made in writing to the PDP sponsor, however, they may not delay processing of a cancellation until the request is made in writing if they have already received a verbal request from the individual of the desire to cancel the enrollment or disenrollment.

60.1.1 - Cancellation of Enrollment

An individual's enrollment can be cancelled only if the sponsor receives the cancellation request prior to the effective date of the enrollment, unless otherwise directed by CMS.

To ensure the cancellation is honored, the PDP sponsor should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment transaction 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 from the CMS enrollment system. In the event the cancellation transaction fails or the PDP sponsor has other difficulty, the PDP sponsor must submit the request to cancel the action to the CMS Retroactive Processing Contractor in order to cancel the enrollment.

The PDP sponsor may submit a transaction to cancel only those enrollment transactions it submitted. To submit an action to cancel an enrollment, the PDP sponsor must submit a transaction code 80 (cancellation of enrollment), with the effective date equal to the effective date of the enrollment being cancelled.

When canceling an enrollment the PDP sponsor must provide a notice to the individual that states that the cancellation is being processed. This notice should be sent within 10 calendar days of the receipt of the cancellation request (see Exhibit 22). This notice must inform the individual that the cancellation should result in the individual remaining enrolled in the health plan in which he/she was originally enrolled, assuming the individual remains eligible to be enrolled in that plan.

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 PDP sponsor must inform the beneficiary that he/she is a member of its plan. If he/she wants to return to the other PDP he/she will have to submit an enrollment request during a valid election period for a prospective enrollment effective date.

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 TRR notification of an individual's reinstatement, the organization has ten (10) days to send the individual a written notice of reinstatement (Exhibit 22a).

60.1.2 - Cancellation of Disenrollment

A voluntary disenrollment request can be cancelled by the individual only if the request for cancellation is made prior to the effective date of the disenrollment, unless otherwise directed by CMS.

To ensure the cancellation is honored, the PDP sponsor 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 out the now-void disenrollment transaction. In the event the PDP sponsor has submitted the disenrollment and is unable to submit the transaction code 81, or has other difficulty, the PDP sponsor then the organization should contact CMS (or the CMS Retroactive Processing Contractor) in order to cancel the disenrollment.

A PDP sponsor may submit a transaction to cancel only those disenrollment transactions it submitted. To submit an action to cancel a disenrollment, the PDP sponsor must submit a transaction code 81 (cancellation of disenrollment), with the effective date equal to the effective date of the disenrollment being cancelled.

The PDP sponsor must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using PDP services (see Exhibit 23). This notice should be sent within 10 calendar days of receipt of the cancellation request. When an organization receives TRR notification of an individual's reinstatement, the organization has ten (10) days to send the individual a written notice of reinstatement (Exhibit 22a).

If the member's request for cancellation occurs after the effective date of the disenrollment, then the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §60.2.2. If a reinstatement will not be allowed, the PDP sponsor should instruct the member to fill out and sign a new enrollment form to re-enroll with the PDP sponsor during an enrollment period (described in §30), and with a current effective date, using the appropriate effective date as prescribed in §30.5.

60.1.3 – When A Cancellation Transaction is Rejected by CMS Systems (TRC 284)

When a PDP sponsor receives a TRC 284 (Cancellation Rejected), while the cancellation remains valid, it could not be processed automatically in CMS' systems. The PDP sponsor must investigate the circumstances behind the rejection. If the rejection was due to incorrect data on the transaction, the PDP sponsor 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 PDP sponsor must promptly submit the request to CMS (or its designee) for resolution.

60.1.4 – Cancellation Due to Notification from CMS (TRC 015)

When a PDP sponsor receives a TRC 015 (Enrollment Cancelled), it indicates that an enrollment must be cancelled. A cancellation may be the result of an action on the part of the beneficiary, CMS or another plan.

Within ten (10) days of receiving the TRC 015, the plan must send the individual an acknowledgment notice of the cancellation (Exhibit 25b).

60.2 - 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) or if the circumstances justify a reinstatement. 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. Disenrollment due to erroneous incarceration or unlawful presence information;

4. Reinstatements Based on Beneficiary Cancellation of New Enrollment;

5. Plan error, and

6. Demonstration of good cause for failure to pay plan premiums and/or Part D-IRMAA timely.

When a disenrolled individual contacts the PDP sponsor to state that he or she was disenrolled due to item 1 (erroneous death indicator), item 2 (erroneous loss of Medicare Part A or B indicator) or item 5 (plan error), and states that he or she wants to remain a member of the PDP, then the PDP sponsor must instruct the member in writing to continue to use PDP services (refer to Exhibit 15, 16, 17 and 18). The PDP must send the notice within ten (10) calendar days of the individual's contact with the sponsor 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 plan sponsor about either item 3 (erroneous incarceration or unlawful presence information), item 4 (reinstatement based on enrollment cancellation of new enrollment) or item 6 (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 to ensure no gaps in coverage occur. As such, a reinstatement does not require an election period. Therefore, reinstatements may be made retroactively. 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 reinstatement on a case-by-case basis. Within ten (10) calendar days of receipt of TRR confirmation of the individual's reinstatement, the sponsor must send the member notification of the reinstatement (Exhibit 22a).

60.2.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator, Erroneous Loss of Part D Eligibility Indicator, Erroneous Incarceration Information, or Erroneous Unlawful Presence Information

A member can be reinstated if he or she was disenrolled in error since the individual continues to be eligible. This may occur in the following situation:

- Erroneous death indicator;
- Erroneous loss of Part D eligibility;
- Erroneous lawful presence status; or
- Erroneous incarceration information.

As outlined in 42 CFR 422.44(c), PDP sponsors have the option of sending notification of disenrollment due to:

- Death;
- Loss of Part A or Part B entitlement; or
- Unlawful presence in the U.S.

The CMS strongly suggests that sponsors send these notices in these three situations, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibits 13, 14 and 37 for model letters.

If CMS involuntarily disenrolls an individual due to incarceration, a notice is required because the individual resides out of the plan's service area. See §50.2.1.6 for notice requirements for disenrollment due to incarceration. Refer to Exhibit 36.

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 Part D eligibility.

Reinstatements for erroneous death indicator or loss of Part D eligibility:
Individuals can dispute the disenrollment due to death indicator or loss of Part D eligibility. In such cases, the PDP sponsor is expected to acknowledge the individual's request for reinstatement and direct him or her to continue to use PDP services while the issue is resolved with the Social Security Administration (SSA). Sponsors may request that such individuals provide evidence of Part D eligibility by a particular date; however, should the individual provide evidence after that date, the error must still be corrected by the PDP sponsor.

To request consideration for reinstatement following disenrollment due to erroneous death indicator or erroneous loss of Part D eligibility, the PDP sponsor must submit to CMS (or its designee) a copy of the letter to the member informing him or her to continue to use PDP coverage until the issue is resolved. The reinstatement request must indicate the date on which this letter was sent to the member. Refer to model letters in Exhibits 15 and 16. When a sponsor receives TRR notification of an individual's reinstatement, the sponsor has ten (10) days to send the individual a written notice of reinstatement (Exhibit 22a).

CMS will attempt to automatically reinstate individuals 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.

Reinstatements for erroneous incarceration or unlawful presence status information:
Individuals alleging disenrollment due to erroneous incarceration information or erroneous unlawful presence status must have their complains reviewed by the PDP sponsor and possibly referred to SSA. PDP sponsors are not required to provide coverage to such individuals while the issue is reviewed by the plan or SSA.

For individuals who contest their disenrollment on these bases, the PDP sponsor should check CMS' systems to see if the incarceration or unlawful presence status has been removed (via audit notification in MARx) and that the person is otherwise eligible to remain enrolled as of the disenrollment effective date. If the individual is otherwise eligible for enrollment, the reinstatement request may be sent to the CMS Retroactive Processing Contractor (RPC) instead of referring the individual to SSA. However, if CMS systems continue to reflect an incarcerated or unlawful presence status, the plan should refer the individual to SSA so that they may review their records and make corrections, as appropriate. If the information or status is determined to be erroneous by SSA, CMS' systems will be updated. The plan may check CMS systems to see if the incarceration or unlawful presence status has been removed, and, if the person is otherwise eligible to remain enrolled, may send the reinstatement request to the CMS RPC. The PDP sponsor will receive notification of the individual's reinstatement from CMS or via the TRR. At that time, services should resume and coverage should be seamless, as though the individual was never disenrolled. CMS suggests that the organization send the member notification of the reinstatement (Exhibit 25a) within ten (10) days of receipt of TRR confirmation of the individual's reinstatement.

60.2.2 - 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 60.1.1. When a cancellation of enrollment in a new plan is properly made, the associated automatic disenrollment from the previous PDP 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 sponsor must send the member notification of the reinstatement (Exhibit 22a).

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 plan sponsor should inform the individual that reinstatement of enrollment is an option only if the individual successfully cancels enrollment in the "new" plan; accordingly, the plan sponsor should refer the individual to the "new" plan to inquire about his or her options.

60.2.3 - 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 sponsor that is a result of an error on the part of the sponsor, the sponsor must restore the enrollment in its records. Additionally, the sponsor must cancel the disenrollment action from CMS's records, if the sponsor 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 sponsor must process the request according to the guidance for processing retroactive enrollment and disenrollment requests including full documentation and explanation as required.

Within ten (10) days of receipt of TRR confirmation of the individual's reinstatement, the sponsor must send the member written notification of the reinstatement (Exhibit 22a).

60.2.4 - Reinstatements Based on a Determination of Good Cause for Failure to Pay Plan Premiums or Part D-IRMAA Timely

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), he or she may request reinstatement no later than 60 calendar days following the effective date of disenrollment. Reinstatement for good cause, pursuant to 42 CFR § 423.44(d)(1)(vi), will occur when:

1. The individual requests reinstatement within 60 days of disenrollment effective date;
2. The individual has been determined to meet the criteria specified below (i.e., receives a favorable determination); and
3. (a) Within three (3) months of disenrollment for nonpayment of plan premiums, the individual pays **in full** the plan premiums owed at the time he or she was disenrolled; or (b) Within three (3) months of disenrollment for nonpayment of Part D-IRMAA, the individual pays **in full** the Part D-IRMAA amounts and any plan premiums owed at the time he or she was disenrolled.

Criteria for Reinstatement: Reinstatement of enrollment for good cause is provided only in rare circumstances in which the member or his or her authorized representative (i.e. the individual responsible for the member's financial affairs)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. Requests for reinstatement must be accompanied by a credible statement (verbal or written) explaining the unforeseen and uncontrollable circumstances causing the failure to make timely payment. An individual may make only one reinstatement request for good cause in the 60-day period.

Generally, these circumstances constitute good cause:

- A serious illness, institutionalization and/or hospitalization of the member or his or her authorized representative (i.e. the individual responsible for the member's financial affairs), that lasted for a significant portion of the grace period for plan premium or Part D-IRMAA payment;
- Prolonged illness that is not chronic in nature, a serious (unexpected) complication to a chronic condition or rapid deterioration of the health of the member, a spouse, another person living in the same household, person providing caregiver services to the member, or the member's authorized representative (i.e., the individual responsible for the member's financial affairs) that occurs during the grace period for the plan premium or Part D-IRMAA payment;
- Recent death of a spouse, immediate family member, person living in the same household, or person providing caregiver services to the member, or the member's authorized representative (i.e., the individual responsible for the member's financial affairs);

- Home was severely damaged by a fire, natural disaster or other unexpected event, such that the member or the member's authorized representative was prevented from making arrangement for payment during the grace period for plan premium or Part D-IRMAA ;
- An extreme weather-related, public safety or other unforeseen event declared as a Federal or state level of emergency prevented premium payment at any point during the plan premium or Part D-IRMAA grace period. For example, the member's bank or U.S. Post Office closes for a significant portion of the grace period; or
- For disenrollments effectuated by CMS for failure to pay Part D-IRMAA, Federal government error (i.e., CMS, SSA or RRB) caused the payment to be incorrect or late, and the member was unaware of the error or unable to take action prior to the disenrollment effective date.

There may be situations in addition to those listed above that result in favorable good cause determinations. If an individual presents a circumstance which is not captured in the listed examples, it must meet the regulatory standards of being outside of the member's control or unexpected such that the member could not have reasonably foreseen its occurrence, and this circumstance had to be the cause for the non-payment of plan premiums or Part D-IRMAA. CMS expects non-listed circumstances will be rare.

Examples of circumstances that do 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 during the grace period;
- Need for prescription medicines or other plan services.

For examples of cases for favorable and unfavorable good cause determinations, see Appendix 4.

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.

The inability to afford premiums or failure to make timely payment by a member or an authorized representative alone is not grounds for a favorable good cause determination and reinstatement. In addition, good cause determinations are not coverage determinations related to coverage and, therefore, are not appealable. (See 42 CFR 423, subpart M.) An individual may not make more than one reinstatement request for good cause in the same 60-day period following disenrollment, including instances in which the initial request resulted in an unfavorable determination. However, an individual has the right to file a grievance against the plan related to the involuntary disenrollment.

An individual who has been disenrolled for failure to pay plan premium, regardless of whether he or she has also been assessed Part D-IRMAA, remains disenrolled from the plan and does not have access to plan coverage of services he or she receives a favorable good cause determination and

the plan receives full payment of the plan premium amounts owed at the time he or she was disenrolled.

An individual who has been disenrolled by CMS for failure to pay Part D-IRMAA remains disenrolled from the plan and does not have access to plan coverage of services until reinstatement occurs and is reported to the plan on the TRR or the plan is contacted by the CMS caseworker after he or she has successfully updated the member's enrollment record in MARx. Once a reinstatement occurs, the individual's disenrollment will be cancelled and his or her coverage will be continuous, assuming the individual continues to be eligible for enrollment in that plan.

60.2.4.1 - Process for Good Cause Determinations for Nonpayment of Plan Premiums

Pursuant to 42 CFR § 423.44(d), CMS has assigned the handling of good cause determinations to plans.

When a disenrolled individual initially contacts the plan sponsor because following disenrollment for failure to pay plan premiums and indicates that he or she "has a good reason for not having paid the premiums", the plan sponsor must:

- Confirm that the request for reinstatement is being made within 60 calendar days of the disenrollment effective date;
- Inform the individual that reinstatement is a possibility only if it is determined that his or her failure to make timely payment was due to circumstances over which he or she had no control and could not reasonably have been expected to foresee;
- Obtain a credible statement from the individual regarding the circumstance that prevented him or her from making timely payment; and
- Obtain affirmation from the individual indicating his or her willingness and ability to pay all overdue plan premiums within three (3) months of the disenrollment date in order for reinstatement to occur.

If all of these preliminary requirements are not met, the individual is not eligible to be considered for reinstatement for good cause. An individual may not make more than one reinstatement request for good cause during the same 60-day period. For example, an individual requesting reinstatement indicates that he had no unusual or unexpected circumstance that caused the nonpayment of premiums and the plan determines that he does not qualify for his case to be reviewed under good cause. The plan is expected to clearly communicate that the individual's request will not be reviewed because the situation does not meet the criteria (e.g., not unusual or unexpected). The individual remains disenrolled and may not make another request for good cause during the same 60-day period following the involuntary disenrollment.

If all of the above criteria are met, the plan will review the request and will make a favorable or unfavorable good cause determination. CMS expects that plans make such determinations within five (5) business days of initial receipt of the request, so that the individual has a reasonable amount of time to make full payment for reinstatement. For requests received by mail, the initial request is considered received by the plan at the time it arrives in the sponsor's mailbox or mailroom. For requests received by fax, the initial request is considered received by the plan at

the time when the fax is received on the sponsor's fax machine. For requests received by telephone, the initial request is considered received by the plan at the time the sponsor's representative receives the incoming call.
There is not additional time allotted for plans to gather information not collected at the point of initial contact. Plans would need to collect any additional data they feel is needed to make a determination and make that determination within five (5) business days of the date on which the individual first contacts the plan. In such cases where the plan does not have sufficient information to determine if the member's circumstances meet the requirements, it should make a good faith effort to collect it within that timeframe (e.g., making multiple attempts on different days and at different times). However, if attempts are unsuccessful, the plan must use the information provided with the initial request to make its determination.

If the plan makes a favorable determination and there are amounts owed to the plan for past due premiums, the plan should notify the individual of this decision within three (3) business days of making the determination. *If the plan offers immediate payment options, such as payment by credit card via phone, it may provide the notification verbally; however, if the individual does not complete the payment at that time, the plan should issue a written notice to ensure that the individual has the information necessary to pay the owed amounts.* This notice will specify the amount owed (i.e., the premiums owed at the time of disenrollment), the date by which payment must be received for reinstatement (i.e., last day of the third month following the disenrollment effective date), where to send payment, and other payment options such as credit card or direct withdrawal from a bank account if offered by the plan. (See Exhibit 21c).

If, at the time the plan makes a favorable determination, there are no amounts owed to the plan for past due premiums, the plan should notify the individual of this decision either verbally or in writing within three (3) business days of making the determination. Exhibit 21f is a model notice for the scenario in which an individual receives a favorable good cause determination and has already paid the amount required for reinstatement. If verbal notification is attempted but unsuccessful, a written notice should be provided. Verbal notification must be documented by the plan to meet CMS' retroactive processing contractor reinstatement submission requirements.

If the plan makes an unfavorable determination, the plan should notify the individual of this decision by phone or in writing within three (3) business days of making the determination.

If an individual has received a favorable good cause determination, reinstatement in CMS systems may not occur until and unless all required payments are made within three (3) months of the disenrollment effective date. If the individual pays all the owed amounts prior to the three-month deadline, the plan should resume coverage at that time and submit the reinstatement request to the CMS Retroactive Processing Contractor.

Plans have additional time beyond the deadline (i.e., three (3) months from the disenrollment effective date) to verify payment by the bank and credit the payment to the member's account with the plan. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five (5) calendar days beyond the payment deadline to process the payment and submit the reinstatement request to the CMS Retroactive Processing Contractor.

Reinstatements for good cause are considered complete by CMS when TRC 287 (Enrollment Reinstated) is sent by CMS to the plan.

Within ten (10) calendar days of receipt of TRR confirmation of the individual's reinstatement, the plan sponsor must send the member notification of the reinstatement (See Exhibit 22a). In an effort to prevent members from falling behind in premium payments in the future, plans are encouraged to educate them on any automated payment mechanisms their plan offers, as well as the availability of selecting automatic premium withhold through their SSA or RRB benefits.

An individual may not be reinstated in cases where:

- the individual pays all plan premiums owed, but does not receive a favorable good cause determination; or
- the individual receives a favorable good cause determination, but does not pay the plan premiums owed within three months of the disenrollment effective date.

In both of these cases, the plan may re-enroll the individual for a prospective enrollment effective date at the individual's request only <u>if</u> he or she 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 the plan and makes his request for reinstatement on April 15 and receives a favorable good cause determination on April 23. 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 by the plan 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 the plan and makes his request on August 10, and does <u>not</u> receive a favorable good cause determination. Mr. Smith may not be reinstated.

Example C: Mr. Smith is disenrolled by the plan 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 contact the plan to request reinstatement. Thus, Mr. Smith does not have a favorable good cause determination, and he may not be reinstated.

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 60.2.3. Plans should not refer these individuals to 1-800-MEDICARE, nor should these cases be considered for reinstatement for good cause.

The above examples apply for disenrollments for either failure to pay plan premiums or failure to pay Part D-IRMAA.

60.2.4.2 – Process for Good Cause Determinations for Nonpayment of Part D-IRMAA

When a disenrolled individual contacts the PDP sponsor following disenrollment for failure to pay Part D-IRMAA and indicates that he or she "has a good reason for not paying the Part D-IRMAA," the PDP sponsor 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 sponsor should also inform the individual that in order to be reinstated, he or she must meet specific good cause standards and must pay all overdue plan premiums and Part D-IRMAA amounts within three months of the disenrollment date in order for reinstatement to occur.

Once a request is made with CMS via 1-800-MEDICARE, a Complaint Tracking Module (CTM) case will be generated for CMS caseworker action. The CMS caseworker will review the request and will make a favorable or unfavorable good cause determination. If the individual provides any documentation to the plan regarding the inability to make timely payment of the Part D-IRMAA, the plan must provide that documentation to CMS (through the CMS account manager) so that it may be considered in making the determination. If CMS makes an unfavorable determination, CMS will notify the individual of the determination. 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 and the CTM will be sent to the plan. If there are amounts owed to the plan for past due premiums, the plan should send notification to the individual within three business days of being informed of the favorable 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), where to send payment, and other payment options such as credit card or direct withdrawal from a bank account, if offered by the plan. (See Exhibit 21b).

Plans have additional time beyond the payment deadline (i.e., three months from the disenrollment effective date) to verify payment by the bank and credit the payment to the individual's account. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five calendar days beyond the payment deadline to process the payment and notify CMS via CTM. Even if an individual has received a favorable good cause determination, the actual reinstatement will not occur until all required payments are made within three months of the disenrollment effective date.

Within 10 calendar days of receipt of TRR confirmation of the individual's reinstatement, the organization must send the member notification of the reinstatement (Exhibit 22a). In an effort to prevent members from falling behind in premium payments in the future, plans are encouraged to educate them on any automated payment mechanisms offered by the plan, as well as the availability of automatic premium withhold from SSA or RRB benefits.

An individual may not be reinstated in cases where:

- the individual pays all Part D-IRMAA amounts and any plan premium amounts owed, but does not receive a favorable good cause determination; or
- the individual receives a favorable good cause determination, but does not pay the Part D-IRMAA amounts and/or any plan premiums owed with three months of the disenrollment effective date.

In both of these cases, the plan may re-enroll the individual for a prospective enrollment effective date at the individual's request, but only if he or she has a valid election period (i.e., AEP, SEP, etc.), following enrollment procedures outlined in Sections 30 and 40.

Example: Mr. Smith is disenrolled by CMS 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 that he must pay the Part D-IRMAA amount he owes by October 31. The plan notifies Mr. Smith that he must also pay the plan premium amount he owes by October 31. Mr. Smith pays his Part D-IRMAA owed amount on October 25. Mr. Smith pays his plan premium owed amount on November 5. Because the plan received Mr. Smith's payment for his owed plan premium amount after the due date, Mr. Smith may not be reinstated. (Note: If Mr. Smith had paid both his owed Part D-IRMAA and plan premiums by October 31, the plan would have had the additional five days to process the payment and he would have been reinstated.)

60.3 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the PDP sponsor or CMS is unable to process the enrollment for the required effective date (as outlined in §30.4), CMS (or its designee) will process a retroactive enrollment.

In addition, auto-enrollment for full-benefit dual eligible as described in §30.1.4 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 a PDP 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.

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. Sponsors 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, sponsors 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 sponsor 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 sponsor 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 record must show that the election was made and received by the sponsor prior to the requested effective date of coverage).

In the event that CMS determines that the sponsor did not notify the member that he/she must use plan services during the period covered by the retroactive enrollment request, a retroactive enrollment request may be denied.

If the request for retroactive enrollment action is due to plan error, the sponsor 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 sponsor has communicated to the affected beneficiary throughout the period in question. The sponsor 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 CMS Regional Office Casework actions

When a sponsor is directed by CMS, such as via an RO caseworker, to submit a retroactive enrollment or disenrollment request to resolve a complaint, the sponsor 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
- 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.

60.4 - Retroactive Disenrollments

If an enrollment was never legally valid (§40.5) 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), 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), a contract violation, 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, sponsors are required to submit the appropriate documentation to CMS (or its designee) for manual review and potential action.

Retroactive disenrollments can be submitted to CMS (or its designee) by the beneficiary or a PDP sponsor. Requests from a PDP sponsor must include supporting evidence (e.g. a copy of the disenrollment request) and an explanation as to why the disenrollment was not processed correctly. PDP sponsors must submit retroactive disenrollment requests to CMS (or its designee) as soon as possible. If CMS (or its designee) approves a request for retroactive disenrollment, the PDP sponsor 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 PDP sponsor (or by the member) in cases where the PDP sponsor has not properly processed a required involuntary disenrollment or acted upon the member's request for disenrollment as required in §40.4.1 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 §30.5.

If the request for retroactive disenrollment action is due to the sponsor's discovery of an incarcerated status (as per § 50.2.1.3) with a retroactive start date, the sponsor must provide confirmation of the incarcerated status including the start date. Such confirmation could include documentation of telephonic communications.

If the request for retroactive disenrollment action is due to plan error, the sponsor 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 sponsor has communicated to the affected beneficiary throughout the period in question, including evidence that the beneficiary was notified prospectively of the disenrollment. The sponsor 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.

60.5 - Retroactive Transactions for Employer/Union Group Health Plan (EGHP) Members

In some cases a Part D sponsor that has both a Medicare contract and a contract with an EGHP arranges for the employer or union to process elections for Medicare-entitled group members who wish to make elections under the Medicare contract. However, there can be a delay between the time the member completes the election through the EGHP and when the election is received by

the PDP sponsor. 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 election within the timeframes described below, must be submitted to CMS (or its designee) for review within the timeframes provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. Repeated errors may indicate an ongoing problem and therefore will be forwarded to the PDP sponsor's CMS Account Manager for compliance monitoring purposes. The PDP sponsor'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 errors.

60.5.1 - EGHP Retroactive Enrollments

The effective date of EGHP enrollments cannot be earlier than the date the enrollment request was completed by the individual. The effective date may be retroactive up to, but not exceeding, 90 days from the date the PDP 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. Enrollments 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 were to be received 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.

No retroactive enrollments may be made unless there has been a valid enrollment request and the PDP sponsor (or EGHP) provided him/her with the explanation of enrollee rights at the time of enrollment. The PDP sponsor should submit such enrollments using the appropriate transaction code. Please 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 Part D organization.

60.5.2 - EGHP Retroactive Disenrollments

The PDP sponsor must submit a retroactive disenrollment request to CMS (or its designee) if an EGHP does not provide the PDP sponsor with timely notification of a member's requested disenrollment. Up to a 90-day 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 §30.5.

The PDP sponsor must submit a disenrollment notice (i.e., documentation) to CMS (or its designee) demonstrating that the disenrollment request was made in a timely fashion (i.e., prospectively), but that the EGHP was late in providing the information to the PDP sponsor. Such

documentation may include an enrollment request made by the member for a different plan and given to the EGHP during the EGHP's open enrollment season. Such documentation should be sent to CMS (or its designee) as soon as possible.

60.6 – Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment (or disenrollment) request for the same individual with the same effective date in the same reporting period. An individual may not be enrolled in more than one PDP 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 PDP into which the individual intends to enroll. If an individual requests enrollment in more than one PDP 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 a PDP and certain MA plan types is permitted, CMS systems will accept such 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 enrollment requests have the same application date.

EXAMPLES

- Two PDP sponsors receive enrollment requests from one individual. PDP #1 receives a form on December 4th and PDP #2 receives a form on December 10. Both organizations submit enrollment transactions, including the applicable effective date and application date. The enrollment in PDP #2 will be the transaction that is accepted and will be effective on January 1 because the application date on the enrollment transaction is the later of the two transactions submitted. Both plans receive the appropriate reply on the TRR.

- Two PDP sponsors receive enrollment requests from one individual for a January 1 effective date. PDP #1 receives a paper enrollment form with all required information on December 5th. The beneficiary completed an enrollment request for PDP #2 by telephone on the same day, December 5th. Both enrollment requests have the same application date, since they were received by the PDP sponsors on the same date. Both enrollments were submitted to CMS prior to the December cut-off date. PDP #1 transmitted the enrollment to CMS on December 5th, the day it received the enrollment request; however, PDP #2 waited December 8th to transmit the enrollment to CMS. The enrollment for PDP #1 will be the transaction that is effective on January 1, as it was the first transaction successfully processed by CMS.

In the event a rejection for a multiple transaction is reported to the PDP sponsor, the sponsor may contact the individual. If the individual wishes to enroll in a PDP offered by the sponsor that

received the multiple transactions reject, s/he must submit a new enrollment request during a valid enrollment period.

60.7 - User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries

Upon receipt of a TRR, PDP sponsors must update their records to accurately reflect each individual's enrollment status. Sponsors 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 PDP sponsors using the "700 series" TRCs that result from UI enrollment changes. In all cases, PDP sponsors 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. PDP sponsors must determine the final disposition of the beneficiary to ensure the correct message is provided in any notice sent. CMS encourages plans 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	Plans 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	Plans must use Exhibit 31**,** "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, plans may use the existing cancellation of enrollment notice as provided in CMS enrollment guidance. If the specific situation warrants, plans may use Exhibit 31 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, you 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), you must send the materials required in CMS enrollment guidance that you would provide for any new enrollment. You must also send Exhibit 31 describing the plan change including the effective date. Ensure that you communicate clearly the impact of the change on plan premiums, cost sharing, and provider networks.

	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 only apply 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, plans should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated changes are retroactive, plans 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 plan 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, plans may use existing confirmation of enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, plans may use Exhibit 31, including in it the new effective date and information about additional premium liability (ensure flexibility in allowing payment arrangements where necessary). Plans 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. Plans must use Exhibit 31. Plans must explain the change in the effective date of coverage, and provide information on the refunding of any premiums paid. Plans 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. Plans must use Exhibit 31. Plans must explain the change in the effective date of the end coverage, and provide information on the refunding of any premiums paid. Plans 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. Plans must use Exhibit 31. Plans 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.

	Plans 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). Plans must use Exhibit 22a to explain the change and that enrollment in the plan is now continuous. Plans 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 - Storage of Enrollment and Disenrollment Request Records

PDP sponsors are required to retain records of enrollment and disenrollment requests (i.e. copies of enrollment forms, etc.) for the current contract period and 10 (ten) prior periods, as stated at 42 CFR §423.505(e)(1)(iii).

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 elections may also be allowed, such as optically scanned forms stored on disk.

Records of PDP enrollment and disenrollment elections made by any other election mechanism (as described in §30.1) must also be retained as above.

APPENDICES

Summary of PDP Notice and Data Element Requirements

Appendix 1: Summary of Notice Requirements

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
Medicare Prescription Drug Plan Individual Enrollment Form (Exh. 1)	40.1.1	Yes[1]	NA
Information to include on or with Enrollment Mechanism -- Attestation of Eligibility for an Enrollment Period (Exh. 1a)	30	No	NA
Short Enrollment Form (Exh. 1b)	20.3	No	NA
Model Plan Selection Form for Switch From Plan to Plan Within Parent Organization (Exh. 1c)	20.3	No	NA
Acknowledge Receipt of Enrollment Request (Exh. 2)	40.4.1	Yes[2]	10 calendar days of receipt of completed enrollment request
Acknowledge Receipt of Enrollment Request – Enrollment in another Plan Within the Same PDP Organization (Exh. 2a)	40.4.1	Yes	10 calendar days of receipt of completed enrollment request
Acknowledge Receipt of Enrollment and Confirmation of Enrollment (Exh. 2b)	40 and 40.4	Yes[3]	7 calendar days of availability of TRR
Request for Information (Exh. 3)	30, 40.2.2	No	NA
Confirmation of Enrollment (Exh. 4)	40.4.2	Yes[4]	10 calendar days of availability of TRR
Individuals Identified on CMS Records As Members of Employer/Union Receiving Employer Subsidy (Exh. 5)	20.4	Yes	10 calendar days of availability of TRR
PDP Organization Denial of Enrollment (Exh. 6)	40.2.3	Yes	10 calendar days of receipt of enrollment request OR expiration of time frame for requested additional information

[1] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[2] Unless combine acknowledgment & confirmation notice, per section 40.4
[3] Required if the PDP sponsor has chosen to provide a single notice in response to the TRR, as described in section 40 and 40.4
[4] Required unless combined acknowledgment/confirmation notice is issued

Notice	Section	Required?	Timeframe
CMS Rejection of Enrollment (Exh. 7)	40.4.3	Yes	10 calendar days of availability of TRR
Send Out Disenrollment Form/ Disenrollment Form (Exh. 8 – 9)	50.1	No	NA
Information to include on or with Disenrollment Form -- Attestation of Eligibility for an Election Period (Exh. 9a)	30.3	No	NA
Acknowledgement of Receipt of Voluntary Disenrollment Request from Member (Exh. 10)	50.1.5	Yes	10 calendar days of receipt of request to disenroll
Final Confirmation of Voluntary Disenrollment Identified Through TRR (Exh. 10a)	50.1.5	Yes	10 calendar days of availability of TRR
Confirm Disenrollment Identified Through TRR – Reassigned LIS (Exh. 10b)	40.1.5	Yes	10 calendar days of availability of TRR
Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan (Exh.10c)	50.4.1	Yes	10 calendar days of availability of TRR
PDP Denial of Disenrollment (Exh. 11)	50.1.5	Yes	10 calendar days of receipt of disenrollment request
Model Notice to Request Information (Disenrollment) (Exh. 11a)	30, 50.4.2	No	NA
CMS Rejection of Disenrollment (Exh. 12)	50.1.5	Yes	10 calendar of availability of TRR
Disenrollment Due to Death (Exh. 13)	50.2.3	Yes	10 calendar days of availability of TRR
PDP Model Notice for auto-enrollments provided by CMS with recent deceased code (Exh. 13a)	40.1.4.D	Yes	10 calendar days of availability of TRR
Disenrollment Due to Loss of Medicare Part A and/or Part B (Exh. 14)	50.2.2	Yes	10 calendar days of availability of TRR
Notices on Terminations/Nonrenewals	note[5]	Yes	Follow requirements in 42 CFR 423.506 - 423.512

[5] Provided under separate CMS guidance

Notice	Section	Required?	Timeframe
Advanced Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	50.3.2	Yes	
Intent to request CMS' permission to disenroll the member	50.3.2	Yes	
Confirmation of Disenrollment for Disruptive Behavior (no exhibit)	50.3.2	Yes	Before disenrollment transaction submitted to CMS
Disenrollment for Fraud & Abuse (no exhibit)	50.3.3	Yes	Before disenrollment transaction submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	60.2, 60.2.1	Yes	10 calendar days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination (Exh. 16)	60.2, 60.2.1	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)	60.2, 60.2.3	Yes	10 calendar days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	60.2	Yes	10 calendar days after information was due to organization
Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage (Exh. 19)	50.3.1	Yes	Within 15 calendar days after the 1st of the month for which delinquent premiums due
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	Yes	10 calendar days of availability of TRR
Involuntary Disenrollment by CMS for Failure to Pay Part D-IRMAA (Exh. 21a)	50.2.6	Yes	10 calendar days of availability of TRR
Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Premium Amount Due for Reinstatement (Exh. 21b)	60.2.4	No	3 business days of receipt of CTM notification of favorable good cause determination
Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums –	60.2.4	No	3 business days following favorable good cause determination

Notice	Section	Required?	Timeframe
Notification of Premium Amount Due for Reinstatement (Exh 21c)			
Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (Exh 21d)	60.2.4	No	3 business days following unfavorable good cause determination
Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment (Exh 21e)	60.2.4	Yes	10 calendar days of the expiration of the 3 month period
Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement) (Exh 21f)	*60.2.4*	*No*	*3 business days following favorable good cause determination*
Acknowledgement of Request to Cancel Enrollment (Exh. 22)	60.1.1	Yes	10 calendar days of request
Confirmation of Reinstatement After Cancelling a Request to Enroll in Another Plan or Reinstatement for Favorable "Good Cause" Determination (Exh. 22a)	60.1.1, 60.1.2, 60.2.1, 60.2.2	Yes	10 calendar days of TRR indicating reinstatement
Acknowledgement of Request to Cancel Disenrollment (Exh. 23)	60.1.1	Yes	10 calendar days of request
Inform member of Auto-enrollment (Exh. 24)	40.1.4.D	Yes	10 calendar days of availability of TRR or address report, whichever is later
Inform member of Facilitated Enrollment (Exh. 25)	40.1.4.D	Yes	10 calendar days of availability of TRR or address report, whichever is later
Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015)(Exh. 25b)	60.1.4	Yes	10 calendar days of TRR confirming cancellation
Request to Decline Part D (Exh. 26)	40.1.4.E & 40.1.4.G	Yes	10 calendar days of request
PDP Acknowledgement of Request to Disenroll from PDP and Opt-Out of Part D After Effective Date (Exh. 26a)	40.1.4.G	Yes	10 calendar days of request
Auto and Facilitated Enrollees Who Permanently Reside in another Region	50.2.1	No	10 calendar days of availability of TRR

Notice	Section	Required?	Timeframe
Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region (Exh. 27)			
Auto and Facilitated Enrollees Who Permanently Reside in another Region Where PDP Sponsor Does Not offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region (Exh. 28)	50.2.1	Yes	10 calendar days of confirmation that individual does not reside in region
Reassignment Confirmation (Exh. 29)	40.1.5E	Yes	10 calendar days of availability of TRR
Optional Notice for "Losing Plan" to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC) (Exh. 30)	40.1.5E	No	
Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes (Exh. 31)	60.7	As necessary	10 calendar days of availability of TRR
Model Employer/Union Group Enrollment Mechanism Notice	40.1.6	Yes	Minimum 21 calendar days prior to effective date of enrollment
Research Potential Out of Area Status (Exh. 33)	50.2.1.3	Yes	10 calendar days of receipt of information indicating potential out-of-area status
PDP Model Notice for Disenrollment Due Out of Area Status (Exh. 34)	50.2.1.3	Yes	Within the first ten calendar days of the 12th month
PDP Notice of Disenrollment Due to Out of Area Status (Exh 35)	50.2.1.3	Yes	Within 10 calendar days of confirmation that out-of-area move was permanent
Notice of Involuntary Disenrollment by the CMS due to Incarceration (Exh. 36)	50.2, 50.2.1	Yes	10 calendar days of notification on the TRR
Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence (Exh. 37)	50.2, 50.2.7	No	10 calendar days of notification on the TRR

Appendix 2: Summary of Data Elements Required for Plan Enrollment Mechanisms and Completed Enrollment Requests

All data elements with a "Yes" in the "Beneficiary response required on enrollment request" column are necessary in order for the enrollment request to be considered complete.

Data Element		Required on enrollment mechanism?	Beneficiary response required on enrollment request?
1	PDP Plan name[6]	Yes	Yes
3	Beneficiary name	Yes	Yes
4	Beneficiary Birth Date	Yes	Yes
5	Beneficiary Sex	Yes	Yes
6	Beneficiary Telephone Number	Yes	No
7	Permanent Residence Address	Yes	Yes
8	Mailing Address	Yes	No
9	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No	No
10	E-mail address	No	No
11	Beneficiary Medicare number	Yes	Yes
12	Additional Medicare information contained on sample Medicare card, or copy of card	Yes	No[7]
13	Plan Premium Payment Option	No	No[8]
14	Other insurance COB information	No	No[9]
15	Long term care question	No	No
16	Beneficiary signature and/or Beneficiary Representative Signature	Yes	Yes[10]
17	Date of signature	Yes	No[11]

[6] If the enrollment mechanism will be used for multiple plans (PBPs), all plan names must be listed in a way that permits the applicant to clearly indicate his/her plan choice.

[7] We recognize that the PDP needs, at a minimum, the Medicare number in order to verify entitlement to Part A and/or enrollment in Part B; we have accounted for the need for this data element under data element number 4.

[8] Response defaults to direct bill if applicant fails to provide information

[9] Refer to CMS COB guidance for additional information

[10] Applicable only to requests made using a paper enrollment form. If signature is missing, plan may follow up and document, as described in Section 30.2. F

[11] As explained in §40.2, the beneficiary and/or legal representative should provide the date s/he completed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment request, then the date of

Data Element		Required on enrollment mechanism?	Beneficiary response required on enrollment request?
18	Authorized Representative contact information (if not signed by beneficiary)	Yes	Yes
19	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
20	Release of Information All elements provided in model language must be included on enrollment request mechanisms.	Yes	Yes
21	Option to request materials in language other than English or in other formats	Yes	No

receipt that the PDP assigns to the enrollment request may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

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.

Election Mechanism	**Application Date**	**Special Notes**
Paper Enrollment Forms §50.1.1	The date the paper request is initially received	Paper requests submitted to or collected by sales agents or brokers are received by the PDP sponsor on the date the agent or broker receives the form
Enrollment forms received by Fax §50.1.1	The date the fax is received on the PDP sponsor's Fax machine	
Medicare.gov Online Enrollment Center (OEC) §50.1.3	The date "stamped" by CMS on the request	
PDP electronic enrollment §40.1.2	The date the request is completed via the sponsor's electronic enrollment 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 §50.1.4	The date of the call	
Other Special Processes for Application Dates	**Application Date**	**Special Notes**
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 §§50.1.3 and 50.1.7
Auto and Facilitated Enrollment §50.1.6	For Part D plans, the application date is set by CMS.	For Cost plans conducting auto- & facilitated enrollment per section 50.1.1 of Chapter 17-D, set the application date to the 1st of the month prior to the effective date of the auto/facilitated enrollment.
SPAP enrollment requests as permitted in §50.1.8 made during the AEP	October 15th	The effective date of enrollment is the following January 1st

Appendix 4: Examples of Good Cause Determinations

This listing is to provide examples to assist plans in making favorable and unfavorable determinations for requests of reinstatement for good cause. For exact detail on the criteria and requirements for good cause reinstatements, see §60.2.

In all these examples, the individual is disenrolled for nonpayment of plan premiums and makes a timely request for good cause reinstatement.

Favorable determination examples:

Example A: Ms. Grey was disenrolled on May 31, 2015 following a plan's two month grace period. She states that she has a caregiver who is responsible for making her premium payments to the plan. Ms. Grey attests that her caregiver caught pneumonia, was hospitalized for over 2 months from late March to late May 2015 and wasn't able to make payments. The plan issues a favorable good cause determination, since the member's caregiver was unexpectedly ill and hospitalized for a significant portion of the plan's grace period, which prevented the caregiver from making arrangements for timely payment. The plan's favorable determination is appropriate because: 1) The credible statement was provided about a serious illness and the person paying premiums was hospitalized for a significant portion of the plan's grace period; 2) The event (illness and hospitalization) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the caregiver could not have paid or made arrangements to pay the owed premiums within the plan's grace period as a result of the illness and hospitalization.

Example B: Mr. Lieber was disenrolled on April 30, 2015 following a plan's two month grace period. He states that he was in a car accident in mid-February, was hospitalized for one month and then sent to an assisted living facility for rehabilitation for one month. He indicated that he wasn't able to pay his bills during that time and didn't have any family to assist him. Because Mr. Lieber's situation was unexpected and he was hospitalized and institutionalized for a significant portion of the plan's grace period, the plan issues a favorable good cause determination. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about a serious illness and that the member was hospitalized and institutionalized for significant portion of the plan's grace period ; 2) The event (illness and hospitalization) was unexpected and out of the person's control; and 3) It is reasonable to conclude that Mr. Lieber could not have paid or made arrangements to pay the owed premiums within the plan's grace period as a result of the illness.

Example C: Ms. Kim was disenrolled on August 31, 2015 following the plan's two month grace period. She states that she was displaced from her apartment due to a building fire in early June, was unable to access her belongings and as a result, was unable to make timely payment. The plan issues a favorable determination because Ms. Kim's home was significantly damaged by an unexpected and uncontrollable event during the plan's grace period. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about that the member's home was severely damaged due to an unexpected event; 2) The event (fire) was unexpected and out of the person's control; and 3) It is reasonable that the damage to Ms. Kim's

home impaired her ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example D: Mr. Jones was disenrolled on June 30, 2015 following a plan's two month grace period. His son states that he found out that his father lost his coverage when he recently visited him. The son states that Mr. Jones was recently diagnosed with dementia and his condition is quickly worsening, which caused him to not pay his premiums. The son states that because of his father's condition, he is taking over financial matters for his father and will pay the arrearages. The plan issues a favorable determination because Mr. Jones was newly diagnosed with a serious illness that directly impacts his ability to pay his premiums. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about a serious and prolonged illness with rapid deterioration, that directly impacted the member's ability to pay premiums timely; 2) The event (serious illness with rapid deterioration) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the onset of dementia caused Mr. Jones to fail to make the timely payment during the grace period.

Example E: Ms. Brown was disenrolled on July 31, 2015 following the plan's three month grace period. She states that for the past four months, her husband was receiving intensive treatment for cancer and she was taking care of him during this time. During this time, she fell behind in paying bills due to the care he needed. The plan issues a favorable determination because Ms. Brown's husband was seriously ill for a prolonged period time during the plan's grace period. The plan's favorable determination is appropriate because: 1) The credible statement was provided about a serious and prolonged illness of an immediate family member; 2) The event (serious and prolonged illness) was unexpected and out of the person's control; and 3) It is reasonable to conclude that Ms. Brown's circumstance in providing caregiver services for her spouse impacted her ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example F: Mrs. Duke was disenrolled on August 31, 2015 following the plan's two month grace period. She states that her husband had been handling her bills and making payments timely. However, he passed away in July 2015, leaving her with no caregiver or family member to take over the responsibility. The plan issues a favorable good cause determination because of the recent death of Mrs. Duke's husband, which was unexpected and out of her control. The plan also offers Mrs. Duke the option to set up electronic payments and premium withholding to help ensure that she remains current in paying her premiums. The plan's favorable determination is appropriate because: 1) The credible statement was provided about the recent death of a spouse; 2) The event (death of spouse) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the unexpected death impacted Mrs. Duke's ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example G: Mr. Santiago lives in Lucas County, Iowa, and was disenrolled on July 31, 2015 following the plan's two month grace period. He states that there were severe storms and significant flooding in his town and the Post Office closed for a week during the grace period while the flooding receded. The plan checks the FEMA.gov website and verifies that Lucas County, Iowa, was declared as a federal disaster area. The plan issues a favorable good cause determination because the declared federal state of emergency occurred during the plan's grace period and that emergency impacted Mr. Santiago's ability to pay his premiums timely. The plan's

favorable determination is appropriate because: 1) The credible statement provided was an extreme weather-related event The event (declared state of emergency) was unexpected and out of the person's control; 2) The event was unexpected and out of the person's control; and 3) It is reasonable to conclude that this circumstance impacted Mr. Santiago's ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Unfavorable determination examples:

Example A: Mr. Smith was disenrolled on June 30, 2015 following the plan's three month grace period. He states that he was unable to pay his plan premiums because he was in the hospital for a week in May for a planned surgical procedure, followed by a two week stay in a rehabilitation facility. The plan issues an unfavorable good cause determination because Mr. Smith was not unexpectedly hospitalized or institutionalized for a significant portion of the plan's grace period. Even though Mr. Smith was away from his home undergoing medical treatment for three weeks, he had a reasonable opportunity and ability to resolve the delinquency within the plan's grace period. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which hospitalization or institutionalization occurred for a significant portion of the plan's grace period; 2) The situation (planned hospital procedure) was not unexpected, nor did it render the individual without control over timely payment of his premiums; and 3) It is reasonable to expect that Mr. Smith could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Smith may not be reinstated for good cause.

Example B: Mr. Jones was disenrolled on May 31, 2015 following the plan's two month grace period. He states that he was unable to pay his plan premiums because he has End-Stage Renal Disease (ESRD) and goes to a facility for dialysis three times a week. Mr. Jones states that he sometimes has difficulty keeping track of his monthly premium billing statements because of his frequent trips to the dialysis facility. The plan issues an unfavorable good cause determination because Mr. Jones has a known health issue and his need for routine dialysis is not unexpected in any way. While he has a chronic illness, he was receiving regular care to treat his condition, and it is reasonable to expect him, or someone acting on his behalf, to resolve the delinquency at some point during the plan's grace period. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which a chronic illness had newly developed serious complications which inhibited the ability to pay premiums timely; 2) The situation (chronic condition with no complications) did not render the individual without control over timely payment of his premiums; and 3) It is reasonable to expect that Mr. Jones could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Jones may not be reinstated for good cause.

Example C: Ms. Ferrera was disenrolled on March 31, 2015 following the plan's two month grace period. She states that she and her family were away from home on an extended vacation and she wasn't aware that she had been disenrolled until they returned home. Ms. Ferrera states that she is willing and able to pay the plan premiums that were not paid and added that she needs her coverage due to her many medications for diabetes. The plan issues an unfavorable good cause determination because Ms. Ferrera did not have a circumstance that was unexpected or unforeseen in any way. While she has a chronic illness and requires medicines to treat her

condition, Ms. Ferrera had the ability to make arrangements to have the premiums paid on time while she was out of town. The plan's unfavorable determination is appropriate because: 1) The credible statement provided of being away from home on vacation is listed specifically as the basis for an unfavorable determination; 2) The situation (planned vacation) was not unexpected in any way; and 3) It is reasonable to expect that Ms. Ferrera could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Ferrera may not be reinstated for good cause.

Example D: Mr. Davis was disenrolled on July 31, 2015 following the plan's two month grace period. He states that earlier in the year he moved a short distance from his previous residence but did not inform the plan of his new address. The plan issues an unfavorable good cause determination because the plan materials clearly state that it is the enrollee's responsibility to inform the plan of a change of address. This is not a case of plan error, since the plan sent the monthly billing statements and the disenrollment notice to the address most recently provided by Mr. Davis. (See §60.3.3 for information in reinstatement following disenrollment due to plan error.) The plan's unfavorable determination is appropriate because: 1) The credible statement provided of an unreported change of address is listed specifically as the basis for an unfavorable determination; 2) The situation (permanent residence change) was not unexpected in any way; and 3) It is reasonable to expect Mr. Davis to inform the plan of his new address, to avoid any delay in his receipt of important materials, such as monthly billing statements and notices regarding his enrollment status. Mr. Davis may not be reinstated for good cause.

Example E: Ms. Adams was disenrolled on April 30, 2015 following the plan's three month grace period. She states that the basement in her home and her electricity were affected by recent flooding and that this prevented her from sending her monthly plan premium payments. Local road closures and power outages lasted for up to a week for some residents. The plan issues an unfavorable good cause determination because the local storms and subsequent flooding did not severely damage Ms. Adams home or prevent her from making the premium payments; further, there was neither a state nor federal disaster declaration. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which the home was severely damaged nor was there a federal or state declaration of emergency; and 2) While road closures and power outages impacted some area residents, it isn't clear that Ms. Adams was directly impacted by these events or was impeded from being able to make timely payment; and 3) It is reasonable to expect that Ms. Adams could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Adams may not be reinstated for good cause.

Example F: Mrs. Johnson was disenrolled on March 31, 2015 following the plan's two month grace period. She states that her husband is responsible for making her premium payments to the plan. Mrs. Johnson attests that her husband became ill, was hospitalized for two weeks in February 2015 and was not able to make payments. The plan issues an unfavorable good cause determination since, although her husband's illness was unexpected, he was not hospitalized for a significant portion of the plan's grace period, which would have caused him to be unable to make the payment in a timely manner. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not that hospitalization or institutionalization occurred for a significant portion of the plan's grace period; and 2) It is reasonable to expect that Mr. Johnson

could have paid or made arrangements to pay the owed amounts for this wife's coverage within the plan's grace period. Mrs. Johnson may not be reinstated for good cause.

Example G: Mr. Patel was disenrolled on September 30, 2015 following the plan's three month grace period. He states that his income decreased and he was unable to afford to pay his premiums. The plan issues an unfavorable good cause determination because there wasn't an unexpected or unforeseen circumstance that prevented payment from being made by Mr. Patel in a timely manner. The plan's unfavorable determination is appropriate because: 1) The credible statement provided of personal financial issues is listed specifically as the basis for an unfavorable determination; and 2) It is reasonable to expect that Mr. Patel could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Patel may not be reinstated for good cause.

Example H: Ms. Ulman was disenrolled on June 30, 2015 following the plan's two month grace period. She states that she needs to refill her medications and that she paid her owed amounts to the plan on July 20, 2015, following her disenrollment effective date. The plan issues an unfavorable good cause determination because Ms. Ulman's need for medications did not inhibit her ability to pay her premiums timely. The plan's unfavorable determination is appropriate because: 1) The situation (medication needs) was not unexpected or out of the person's control, nor did it impede her ability to pay timely; and 2) It is reasonable to expect that Ms. Ulman could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Ulman may not be reinstated for good cause.

Example I: Ms. Taylor was disenrolled on March 31, 2015 following a plan's three month grace period. She states that when she enrolled in the plan during the fall open enrollment period, she selected premium withhold as the method of premium payment. She says that she received a premium bill from the new plan for January and, in addition, received a delinquency notice in early January warning of disenrollment at the end of March if she did not pay the premium for January. She stated that she ignored the bill and the delinquency notice, assuming that her plan premiums were being withheld from her Social Security benefit check starting with the January premium. The plan issues an unfavorable good cause determination because the plan explained in its letter to Ms. Taylor following submission of the enrollment transaction and receipt of the TRR that her first month's plan premium was not withheld, that she was responsible for paying her premiums until premium withholding started and that she could be involuntarily disenrolled. The plan concluded that Ms. Taylor had been appropriately advised of her obligation to pay the bill for the January premium and that this was reiterated by means of the subsequent premium bills and the delinquency letter the plan sent to her in January. The plan's unfavorable determination is appropriate because: 1) The situation (misunderstanding of ramifications of nonpayment of premiums) was not unexpected in any way; 2) The situation did not impede her ability to pay timely; and 3) It is reasonable to expect that Ms. Taylor could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Taylor may not be reinstated for good cause.

EXHIBITS

PDP Model Enrollment Forms & Notices

This section contains model exhibits for plan issued notices to beneficiaries regarding enrollment matters. PDP sponsors 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 - PDP Model Enrollment Form

[Logo/Name of the Medicare Drug Plan]

<PDP Name> Medicare Prescription Drug Plan Individual Enrollment Form
Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <PDP 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: ( )
Permanent Residence Street Address (P.O. Box is not allowed):			
City:	State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
Emergency contact: [Optional field] _____ **Phone Number**: [Optional field]_____ **Relationship to You** [Optional field] _____			
[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 or Part B (or both) to join a Medicare prescription drug plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

Paying Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you 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. 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. Do NOT pay the Part D-IRMAA extra amount to <PDP name>.**

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 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 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: "coupon", "payment" book, etc>
<*option to include other billing intervals e.g. bi-monthly, quarterly*>

<*Include other optional 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 benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please Answer the Following Questions:

1. 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 <PDP 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 this coverage: _____ Group # for this coverage: _____

2. 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):_____

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 (e.g. Braille, audio tape, or large print)>

Please contact <PDP name> at <phone number> if you need information in another format or language than what is listed above. TTY users should call <TTY number>. Our office hours are <insert days and hours of operation>.

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining <PDP name>, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from an employer or union, joining <PDP Name> could affect your employer or union health benefits. You could lose your employer or union health coverage if you join <PDP 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 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:

<PDP Name> is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform <PDP name> of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in <PDP name> will end that enrollment.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

<PDP Name> serves a specific service area. If I move out of the area that <PDP Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use <PDP name> network pharmacies. Once I am a member of <PDP Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from <PDP name> when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <PDP name>, he/she may be paid based on my enrollment in<PDP name>.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that <PDP Name> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <PDP Name> will release my information, 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 State law 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 by 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 _____

Medicare Prescription Drug Plan Use Only:

Plan ID #:_____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Name of Plan Representative/agent/broker:_____

[*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

Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment 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 was released from incarceration. I was released 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 recently obtained lawful presence status in the United States. I got this status 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 drug coverage. I stopped receiving extra help on (insert date) _____.
- ☐ I 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 (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 am making this enrollment request between January 1 and February 14, and I recently ended my enrollment in a Medicare Advantage plan. I left my Medicare Advantage plan on (insert date) _____.

If none of these statements applies to you or you're not sure, please contact <plan name> at <phone number> to see if you are eligible to enroll. We are open <insert days and hours of operation>. TTY users should call <TTY number>.

Exhibit 1b – Model Short Enrollment Form ("Election" may also be used)

This form may be used in place of the model individual enrollment form when a member of a PDP sponsor is enrolling into another plan benefit package offered by the same parent organization.

Referenced in section(s): 20.3, 40.1.2, Appendix 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:	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 <PDP name> with a monthly premium of $_____ . I would like to change to the _____ plan in <PDP name>. I understand that this plan has different prescription benefits and a monthly premium of $_____.		
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> 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>.		

Your Plan Premium
You can pay your monthly plan premium (including any late enrollment penalty you 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 benefits 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. DON'T pay <plan name> the Part D-IRMAA extra 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 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: Include other optional methods, such as EFT & credit card*>

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please Read and Sign Below:

<PDP name> is a Medicare prescription drug plan and 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 compensated based on my enrollment in<plan name>.

Release of Information: By joining this Prescription Drug Plan, I acknowledge that the Prescription Drug 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, 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 Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date [name of plan] coverage begins, I must get all of my prescription drug services from <plan name>. Prescription drugs authorized by <plan name> and 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 behalf of the individual under the laws of the State where the individual resides) 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 by 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 _____**	

Medicare Prescription Drug Plan Use Only:

Plan ID #:_____

Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____

Name of Plan Representative/agent/broker:_____

[*optional space for other administrative information needed by plan*]

Exhibit 1c: Model Plan Selection Form for Switch from Plan to Plan within Parent Organization

Referenced in section(s): 10, 40, 40.1, 40.2

Dear <plan name> Member:

<Introduction - In the introduction of cover letter, PDP sponsor may include language regarding plan choices, description of plans, differences, etc.>.

To make a change in the Medicare Prescription Drug plan you have with <name of PDP sponsor>, 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 Part D plans only at certain times during the year. Between October 15th and December 7th each year, anyone can join our plan. 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 use any <current plan name> pharmacies.

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 Part D plan to the Part D 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: deductible, copays, etc.>

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: deductible, copays, etc.>

Your Plan Premium

You can pay your monthly plan premium 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/Railroad Retirement Board benefit 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 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 or Railroad Retirement Board benefit check or be billed directly by Medicare. DON'T pay <plan name> the Part D-IRMAA extra amount.

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/Railroad Retirement Board benefit check. (The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board 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 2 - PDP Model Notice to Acknowledge Receipt of Completed Enrollment

Referenced in section: 40.4.1

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

<Date>
Dear <Name of Member>:

Thank you for enrolling in <PDP name>. <PDP name> is a Prescription Drug Plan that is approved by Medicare. Your enrollment will be effective on <effective date>.

How will this coverage work?
As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <PDP name> may not pay for your prescriptions. [***Optional language*:** This letter is proof of your <PDP name> coverage. You should show this letter at the pharmacy until you get your Member ID card from us.]

How much is my premium?
Medicare must approve all enrollments and calculate your premium amount. When Medicare approves your enrollment into <PDP name>, we will send you a letter to confirm your enrollment in <PDP name>. You will get a separate letter from <PDP name> once Medicare calculates your premium. You should not wait to get these confirmation letters before you begin using <PDP name> network pharmacies on <effective date>. If Medicare rejects your enrollment, <PDP name> will bill you for any prescriptions you received through us.

[*PDP plans without a premium – do not use the following Q&A*:
Will <PDP name> bill me directly for my premiums or will my premiums be deducted from my Social Security/Railroad Retirement Board check?
Your enrollment form included the options for paying your plan premium. If you chose to have your <PDP name> premium withheld from your Social Security or 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 or doesn't start at all. If you didn't choose this option, we will bill you for your monthly premiums. Generally you must stay with the premium payment 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 <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

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.

What if I have other health coverage?
If you have other health coverage, such as from an employer or union, joining <PDP Name> may change how your current coverage works. Read the communications your other health coverage 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. If you have other prescription drug coverage, such as through an employer plan, you shouldn't cancel your other coverage yet. Keep your other coverage until you receive the confirmation letter from us.

What if I have Medigap (Medicare Supplemental Insurance) coverage?
If you have a Medigap (Medicare Supplement Insurance) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

When can I make changes to my Medicare prescription drug 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 if you move out of <PDP name>'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.

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 questions about how or when to disenroll from <PDP name>, please call our customer service department.

Where can I fill my prescriptions?
Please remember that you should use <PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

What if I have more questions?
If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 2a - Model Notice to Acknowledge Receipt of Completed Enrollment Request for another Plan in the Same Parent Organization

Referenced in section: 40.4.1

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

<Date>
Dear < Member>:

Thank you for the request to change your enrollment from <former PDP name> to <new PDP name>. <New PDP name> is a Prescription Drug Plan that is approved by Medicare. Your enrollment will be effective on <effective date>.

How will this coverage work?
As of <effective date>, you should begin using <new PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <new PDP name> may not pay for your prescriptions. [*Optional language***:** This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us**.]**

How much is my premium?
Medicare must approve all enrollments and calculate your premium amount. When Medicare approves your enrollment, we will send you a letter to confirm your enrollment with <new PDP name>. You will get a separate letter from <PDP name> once Medicare calculates your premium. But, you should not wait to get these confirmation letters before you begin using <new PDP name> network pharmacies on <effective date>.

When can I make changes to my prescription drug coverage?
Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help in paying for your prescription drug costs (see below). **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. 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 questions about how or when to disenroll from <new PDP name>, please call our customer service department at the phone number at the end of this letter.

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.

[*PDP plans without a premium – do not use the following Q&A*:
Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security/Railroad Retirement Board check?
Your enrollment form included the options for paying your plan premium. If you chose to have your monthly premium for this plan withheld from your Social Security or Railroad Retirement Board payment, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away or doesn't start at all. If you did not choose this option, we will bill you for your monthly premium. Generally you must stay with the premium payment 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 <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence*: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

Where can I fill my prescriptions?
Please remember that you should use <new PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <new PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

What if I have more questions?
If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 2b - PDP Model Notice to Acknowledge Receipt of Completed Enrollment and to Confirm Enrollment

Referenced in section: 40.4.1

<Member #>
<RxID>
<RxGroup>
<RxBin]>
<RxPCN>

<Date>
Dear <Name of Member>:

Thank you for enrolling in <PDP name>. <PDP name> is a Prescription Drug Plan that is approved by Medicare. Medicare has approved your enrollment in <PDP name> beginning <effective date>.

How will my coverage work?
As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service department. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.] [*Optional language***:** This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us**.**]

How much is my premium?
[*Insert the following if no low-income subsidy:* The premium for your plan is: [insert premium]. 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 <PDP name> at the number provided at the end of this letter.

[*Insert 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:

- <plan premium less premium assistance for which individual is eligible> per month for your <PDP name> premium,
- <insert appropriate LIS deductible amount > for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> when you fill a prescription.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please call <PDP name> at the number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[*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 number provided at the end of this letter. You can also get information by visiting www.medicare.gov on the web 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.] If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.]

[*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.]

[*Part D plans without a premium – do not use the following paragraph*:
Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security check?
Your enrollment form included the options for paying your plan premium. If you chose to have your <PDP name> premium withheld from your Social Security or 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 or doesn't start at all. If you didn't choose this option, we will bill you for your monthly plan premiums. Generally you must stay with the premium payment 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 <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

[*Insert if low-income subsidy NOT applicable:*
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.]

What if I have Medigap (Medicare Supplemental Insurance) coverage?
If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

What if I have more questions?
If you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 3 - Model Notice to Request Information

Referenced in section: 30, 40.2.2

<Date>

Dear <Name of Member>:

Thank you for applying with <PDP name>. We cannot process your enrollment until we get the following information from you:

_____ Proof that you have Medicare Part A and/or Part B. Please send us a copy of your Medicare card as proof of your Medicare coverage.

_____ Other: _____

You will need to provide this information to <PDP name> by <date>. You can contact us by phone with this information by calling <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. Or, you may also fax it to us at <fax number> or send it to us at <address>. If you cannot send this information by <date>, we will have to deny your request to enroll in our Plan.

Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'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 coverage (see below). **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.

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 <PDP name> at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 4 - PDP Model Notice to Confirm Enrollment

Referenced in section: 40.4.2

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

<Date>

Dear <Name of Member>:

Medicare has approved your enrollment in <PDP name> beginning <effective date>.

How will my coverage work?
As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service department at the number at the end of this letter. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

[*Optional language*: This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us.]

[*Insert the following if no low-income subsidy:*
How much is my premium?
The monthly premium for your plan is <premium amount>.

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 think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <PDP name> at the number provided at the end of this letter.]

[*Insert 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:

- <plan premium less premium assistance for which individual is eligible> per month for your <PDP name> premium,
- <insert appropriate LIS deductible amount > for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount > when you fill a prescription covered by <PDP name>.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <PDP name> at the phone number provided at the end of this letter.]

Will I pay a late enrollment penalty as part of my premium?
[*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. If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.]

[*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.]

[*Part D plans without a premium – do not use the following paragraph*:
Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security/Railroad Retirement Board check?
Your enrollment form included the options for paying your plan premium. If you chose to have your <PDP name> premium withheld from your Social Security or 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 or doesn't start at all. If you didn't choose this option, we will bill you for your monthly premiums. Generally you must stay with the premium payment 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 <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence*: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

What if I have a Medigap policy?
If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

What if I have more questions?
If you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 5 - PDP Model Notice to Individuals Identified on CMS Records As Members of Employer/Union Group Receiving Employer Subsidy

Referenced in section: 20.4

<Date>

Dear < Member>:

Thank you for applying with <PDP name>. To finalize your enrollment, we would like you to confirm that you want to be enrolled in <PDP name>.

Medicare has informed us that you belong to an employer or union group health plan that includes prescription drug coverage that is as good as Medicare prescription drug coverage.

It is important that you consider your decision to enroll in our Plan carefully. If you have health coverage from an employer or union, joining <PDP Name> may change how your current coverage works. You could lose your employer or union health coverage, and if you have a spouse or dependents, their coverage also could be lost. 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

If you have already discussed this decision with your employer or union contact and have decided that you would like to be a member of <PDP name>, **please call <PDP name> at the phone number provided below.** Your enrollment won't be complete until you call and confirm this information.

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.

To confirm your enrollment and your effective date of <effective date>, or if you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 6 - PDP Model Notice for Denial of Enrollment

Referenced in section: 40.2.3

<Date>

Dear <Name of Beneficiary>:

Thank you for applying with <PDP name>. We cannot accept your request for enrollment in <PDP name> because of the reason(s) checked below.

1. _____ You have neither Medicare Part A nor Part B.
2. _____ You are unlawfully present in the United States.
3. _____ You are incarcerated and currently reside outside our service area.
4. _____ Your permanent residence is outside of our service 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. _____ You have drug coverage such as from an employer or union and you told us you don't want to join <PDP name>.]

If <PDP name> paid for any of your prescriptions, we will bill you for the amount we paid.

[Insert if item 2 or 3 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S. or if you're incarcerated]

If item 5 is checked, remember that you can enroll in and disenroll from a Medicare prescription drug plan only at certain times during the year. If you meet certain special exceptions, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, you may enroll in a new plan. Otherwise, you can only enroll in a plan, disenroll from a plan, or switch plans from October 15 through December 7 of each year.

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 any of the checked items are wrong, or if you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 7 – PDP Model Notice for CMS Rejection of Enrollment

Referenced in section: 40.4.2

<Date>

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 <PDP name> due to the reason(s) checked below.

1. _____ You have neither Medicare Part A nor Part B.
2. _____ You are unlawfully present in the United States.
3. _____ You are incarcerated and currently reside out of our service area.
4. _____ You requested to enroll in a different Plan for the same effective date, which canceled your enrollment with <PDP name>.
5. _____ You attempted to enroll outside of an enrollment period.

If <PDP name> paid for any of your prescriptions, we will bill you for the amount we paid.

[Insert if item 2 or 3 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S. or if you're incarcerated]

If item 5 is checked, remember that you can enroll in and disenroll from a Medicare prescription drug plan only at certain times during the year. If you meet certain special exceptions, such as if you move out of <PDP name>'s service area or want to join a plan in your area with a 5-star rating, you may enroll in a new plan. Otherwise, you can only enroll in a plan, disenroll from a plan, or switch plans from October 15 through December 7 of each year.

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 any of the checked items are wrong, or if you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 8 - PDP Model Notice to Send Out Disenrollment Form

Referenced in section: 50.1

<Date>

Dear <Member>:

Attached is the <PDP name> disenrollment form you requested. Please read the important instructions in this letter regarding requesting disenrollment from <PDP name>.

When can I disenroll from <PDP name>?
Medicare will only allow you to disenroll at certain times during the year. After we receive your disenrollment form, <PDP name> will let you know if you can disenroll at this time. If you can disenroll, we will also tell you the effective date of your disenrollment.

Until your disenrollment date, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy except in an emergency, <PDP name> may not pay for your prescriptions. After your disenrollment date, <PDP name> won't cover your prescription drugs.

When can I make changes to my Medicare 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 if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help in paying for your prescription drug costs (see below). 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.

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 submit a disenrollment request?
You **should not** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan. Enrolling in a prescription drug plan or a Medicare Advantage-Prescription Drug Plan will automatically disenroll you from <PDP name>.

You **should** fill out the attached form only if you no longer want Medicare prescription drug coverage and want to disenroll from this coverage completely.

If you would like to disenroll from <PDP name>, please fill out the form, sign it, and send it back to us in the enclosed envelope. You can also fax a signed and dated form to us at <fax number>.

Instead of sending a disenrollment request to <plan name> you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

By disenrolling from <PDP name>, you are disenrolling from your Medicare prescription drug coverage. You may have to pay a late enrollment penalty in addition to your premium for Medicare Prescription Drug coverage if you join a Medicare Drug Plan in the future. For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Attachment

Exhibit 9 - PDP Model Disenrollment Form

Referenced in section: 50.1

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of your effective date after we get this form from you.

Instead of sending a disenrollment request to <plan name> you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

Last Name: First Name: Middle Initial:			☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Member ID:			
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )	

<u>By completing this disenrollment request, I agree to the following:</u>

<PDP name> will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at <PDP name> network pharmacies to get coverage. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I don't have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

Signature* _____ Date: _____

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 Medicare.

If you are the authorized representative, you must provide the following information:

Name : _____
Address: _____
Phone Number: (___) ____- _____
Relationship to Enrollee _____

Exhibit 9a: Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

Referenced in section: 30.3

Typically, you may disenroll from a Medicare prescription drug plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to disenroll from a Medicare prescription drug 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 10 - PDP Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

Referenced in section: 50.1.5

<Date>

Dear < Member>:

We received your request to disenroll from <PDP name>. You will be disenrolled starting <effective date>. Therefore, beginning <effective date>, <PDP name> won't cover your prescription drugs.

Until <effective date>, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions.

What should I do now?
If you have already enrolled in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage), you should receive confirmation of your enrollment from your new Plan. If you have not enrolled in another Medicare Plan, you should consider enrolling in one. If you do not enroll in a new plan at this time or you do not have or obtain creditable prescription drug coverage (as good as Medicare's), 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/Railroad Retirement Board benefit, please allow up to 3 months for us to process a refund. If you have not received a refund from Social Security/the Railroad Retirement Board within 3 months of this letter, you should contact 1-800-MEDICARE.

When can I make changes to my Medicare 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. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help in paying for your prescription drug costs (see below). 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.

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.

Where can I get more information?
For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 10a - PDP Notice to Confirm Voluntary Disenrollment Identified Through TRR

Referenced in section: 50.1.5

<Date>

Dear <Name of Member>:

This is to confirm your disenrollment from <PDP name>. Beginning <effective date>, <PDP name> won't cover your prescription drugs.

What should I do now?
If you have already enrolled in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage), you should get confirmation of your enrollment from your new Plan. If you haven't enrolled in another Medicare Plan, you should consider enrolling in one. If you don't enroll in a new Plan at this time, or you don't have or get creditable prescription drug coverage (as good as Medicare's), 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/Railroad Retirement Board benefit check?
If your Medicare Part D premium is being deducted from your Social Security/Railroad Retirement Board benefit, please allow up to 3 months for us to process a refund. If you have not received a refund from Social Security/the Railroad Retirement Board within 3 months of this letter, you should contact 1-800-MEDICARE.

When can I make changes to my Medicare 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. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help in paying for your prescription drug costs (see below). 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.

Where can I get more information?
For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you think you didn't disenroll from <PDP name> and you want to stay a member of our plan, please call us right away at <toll-free number> <days and hours of operation> so we can make sure you stay a member of <PDP name>. Medicare gives you only 30 days from the date of this letter to contact us. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 10b – PDP Notice to Confirm Disenrollment Identified Through Transaction Reply Report – Reassigned LIS

Referenced in section: 40.1.5 (E)

<Date>

Dear <Name of Member>:

This is to confirm your disenrollment from <PDP name>. Beginning <effective date>, <PDP name> won't cover your prescription drugs. You got a blue letter from Medicare in October explaining that Medicare will switch you to another Medicare drug plan starting January 1, <following calendar year>. This is because it will cost you more if you stay in <PDP name>.

If you haven't already, you should soon get a letter from your new plan confirming your enrollment that will take effect on January 1, <following calendar year>.

You can call this new plan with questions about their coverage, formulary, and pharmacy list.

If you have questions about why Medicare changed your plan or other Medicare plans available in your area, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048).

If you have questions about this disenrollment from <PDP name> or you want to remain a member of our plan, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 10c: Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan

Referenced in section: 50.4.1

IMPORTANT INFORMATION ABOUT YOUR UPCOMING DISENROLLMENT FROM YOUR MEDICARE PRESCRIPTION DRUG PLAN

<Date>

Dear <Name of Member>:

Your state has enrolled you into a new plan that will provide all of your Medicare and Medicaid benefits, including prescription drugs. You should have already gotten a letter from your state telling you about the new plan.

This letter confirms your disenrollment from <PDP name>. You will continue to get your Medicare benefits from <PDP name> until <disenrollment effective date>. Beginning <day following disenrollment effective date>, your new plan will cover your health care.

You will be automatically enrolled in your new plan starting <day following disenrollment effective date>, so you don't have to do anything if you want to be a member of this new plan. In a few weeks, you should get a letter from your new plan confirming your enrollment. **There will be no gap in your Medicare and Medicaid coverage,** including your prescription drug coverage.

The letter from your new plan will tell you how to contact them. You can call your new plan with questions about your new coverage or to see if you can still see your current doctors in your new plan. You can also ask for lists of network primary care providers, covered drugs and pharmacies.

If you have questions about your disenrollment from <PDP name>, please call us at <phone number> (TTY users should call <TTY number>). We are open <days and hours of operation>. If you do not wish to be automatically enrolled in a new plan, call your state or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use a TTY. You can also call 1-800-MEDICARE if you have questions about Medicare or need help with your Medicare options.

Thank you.

Exhibit 11 - PDP Notice for Part D Plan Denial of Disenrollment

Referenced in section: 50.1.5

<Date>

Dear <Member>:

We recently got your request to disenroll from <PDP name>. We cannot accept your request for disenrollment for the reason checked below:

1. _____ You attempted to make a change to <PDP name> outside of an enrollment period. Medicare limits when and how often you can make changes to your coverage.

2. _____ The request was made by someone other than the enrollee and that individual isn't the enrollee's authorized representative.

3. _____ We didn't get the information we requested from you within the timeframe listed in our request.

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. Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or you qualify for extra help in paying for your prescription drug costs (see below). 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.

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 <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

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 <PDP 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:

<PDP 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), 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.

Thank you.

Exhibit 12 - PDP Model Notice for CMS Rejection of Disenrollment

Referenced in section: 50.1.5

<Date>

Dear < Member>:

Medicare has denied your disenrollment from <PDP name> because you have attempted to make a change to your plan outside of an enrollment period. Medicare limits when and how often 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. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'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 (see below). 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.

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 this information is wrong, or if you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 13 - PDP Model Notice of Disenrollment Due to Death

Referenced in section: 50.2.3

<Date>

To the Estate of < Member> :

Medicare told us about the death of <Name of Member>. Please accept our condolences.

<Member>'s coverage in <PDP name> ended as of <disenrollment effective date>. If plan premiums were paid for any month after <disenrollment effective date>, we will issue a refund to the Estate within 30 days of this letter.

If the Medicare Part D premium was being deducted from <Name of Member>'s Social Security benefit, please allow up to 3 months for us to process a refund. If the estate has not received a refund from Social Security within 3 months of this letter, a representative of the estate should contact 1-800-MEDICARE.

If this information is wrong, please contact your local Social Security office to have their records corrected. You can call Social Security at 1-800-772-1213 from 7:00 am to 7:00 pm, Monday to Friday. TTY users should call TTY 1-800-325-0778. If you have any questions, please call <PDP name> at <phone number>. TTY users should call <TTY/TDD number>. We are open <days and hours of operation>.

Thank you.

Exhibit 13a - PDP Model Notice for auto-enrollments provided by CMS with recent deceased code

Referenced in section: 40.1.4.F.

<Date>

To the Estate of < Member> :

Medicare told us about the death of <Name of Member>. Please accept our condolences.

We are sending this letter because Medicare had enrolled <Name of Member> in <PDP name>, a plan that provides Medicare prescription drug coverage. Because of this report of death, <Name of Member>'s coverage in <PDP name> ends as of <disenrollment effective date>. If plan premiums were paid for any month after <disenrollment effective date>, we will issue a refund to the Estate within 30 days of this letter

If this information is wrong, please contact your local Social Security office to have their records corrected. You can call Social Security at 1-800-772-1213 from 7:00 am to 7:00 pm, Monday to Friday. TTY users should call 1-800-325-0778. If you have any questions, please call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 14 - PDP Model Notice of Disenrollment Due to Loss of Part D Eligibility

Referenced in section: 50.2.2

<Date>

Dear < Member>:

Medicare has told us that you no longer have Medicare <Insert A and/or B as appropriate>. Therefore, your membership in <PDP name> ended on <disenrollment effective date>. If your plan premium was paid for any month after <disenrollment effective date>, we will send you a refund within 30 days of this letter.

If you haven't already done so, please contact your local Social Security office to have their records corrected. Or, you can call Social Security at 1-800-772-1213 from 7:00 AM to 7:00 PM, Monday to Friday. TTY users should call 1-800-325-0778.

If this information is wrong, and you want to stay a member of our plan, please contact us. If you have any questions, please call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 15 - PDP Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in section: 60.2, 60.2.1

<Date>

Dear < Member>:

Medicare's 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. After you do this, please send us written proof at <address>. When we get this proof, we will share it with Medicare.

In the meantime, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you for your continued membership in <PDP name>.

Exhibit 16 - PDP Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Termination

Referenced in section: 60.2, 60.2.1

<Date>

Dear < Member>:

On <date of request>, you told us that your enrollment in Medicare <insert Part A and/or Part B as appropriate> was ended in error and that you want to stay a member of <PDP name>.

[*Sponsors 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 your local Social Security office and ask them to correct their records. Or, you can call Social Security at 1-800-772-1213 from 7:00 AM to 7:00 PM, Monday to Friday. TTY users should call 1-800-325-0778.

2. Ask Social Security to give you a letter that says they have corrected your records.

3. Send the letter from Social Security to us at: <address of PDP name> 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 Medicare to correct its records.]

[*Sponsors 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 <PDP name> network pharmacies to fill your prescriptions to get <PDP name> prescription coverage. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

[*Sponsors that are able to verify current Medicare entitlement may omit the following*:
If we learn that you don't have Medicare <insert Part A and/or Part 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 prescription drugs you filled after <disenrollment date>.]

If you have any questions or need help, please call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you for your continued membership in < PDP name >.

Exhibit 17 - Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error

Referenced in section: 60.2, 60.2.2

<Date>

Dear < Member>:

Thank you for letting us know you want to remain a member of <PDP name> after we mistakenly [*select one based on 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 <PDP name>. You should keep using your <PDP name> pharmacies to fill your prescriptions.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you for your continued membership in <plan name>.

Thank you.

Exhibit 18 - PDP Model Notice to Close Out Request for Reinstatement

Referenced in section: 60.2

<Date>

Dear < Beneficiary>:

We cannot process your request to be reinstated in <PDP name> because we haven't gotten the information we requested. As discussed in our letter dated <date of letter>, you were required to 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 <PDP name> paid any costs for prescriptions you filled after <effective date>, we will bill you for the amount we paid.

Please remember that if you don't have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 19 - PDP Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment

Referenced in section: 50.3.1

<Date>

Dear < Member>:

Our records show that we haven't gotten payment for your < PDP name > plan premium as of <date>. If we don't get payment by <insert last day of grace period>, we will have to disenroll you from <PDP name>. To avoid disenrollment, you must pay <amount due to avoid disenrollment> by <insert last day of grace period>. If we do not receive your payment by <insert last day of grace period>, we will ask Medicare to disenroll you from <PDP name> beginning <effective date>.

This letter applies only to your <PDP name> benefits. Your other Medicare benefits won't be affected if you are disenrolled from <PDP name>.
If you don't want to be a member of <PDP name> and don't want any other Medicare drug plan, you may be able to disenroll from <PDP name>. However, Medicare limits when you can make changes to your coverage. You can only enroll in a new plan or disenroll from <PDP name> from October 15 through December 7 each year unless you meet certain special exceptions, such as if you move out of <PDP name>'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. Also, if you don't have or get 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 for Medicare prescription drug coverage in the future.

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 want to disenroll from < PDP name > now, you should do one of the following:

1. Send us a written request at <address>.
2. Call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048. TTY users should call 1-877-486-2048.

If you paid the premium recently and you think we have made a mistake, or if you have any questions, please call < PDP name > at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free TTY number>.
Thank you.

Exhibit 20 - PDP Notice of Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment

Referenced in section: 50.3.1

<Date>

Dear < Member>:

On <date of notification letter>, we mailed you a letter stating that your plan premium was overdue. The letter said that if you didn't pay your premium, we would disenroll you from < PDP name >. Since we didn't get that payment, we have asked Medicare to disenroll you. Your disenrollment from < PDP name > will be effective <effective date>. After <effective date>, < PDP name > won't cover your prescription drugs.

This letter only applies to your <PDP name> benefits. Your other Medicare benefits aren't affected by your disenrollment from < PDP name >. [*Cost plans where individual is losing optional supplemental Part D benefit only, replace prior sentence with:* This letter only applies to your prescription drug coverage. You will still have health coverage through <*cost plan name*>.]

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 us to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If we approve your request, you will have to pay all owed premium amounts within three (3) months of your disenrollment in order to get your coverage back. To ask us to review this decision, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. You must make your request no later than <insert the date that is 60 calendar days after the disenrollment effective date>.

When can I get Part D 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 < PDP name >'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.

Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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 Part D 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 <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 21 - PDP Notice of Failure to Pay Plan Premium - Confirmation of Involuntary Disenrollment

Referenced in section: 50.3.1

<Date>

Dear < Member>:

Medicare has confirmed your disenrollment from < PDP name > because you didn't pay your plan premium. Your disenrollment begins <effective date>. As of <effective date>, <PDP name> won't cover your prescription drugs.

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 us to review this decision if you had to be an emergency or unexpected situation that kept you from paying your premiums on time. If we approve your request, you will have to pay all owed premium amounts within three (3) months of your disenrollment in order to get your coverage back. To ask us to review this decision, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. You must make your request no later than <insert the date that is 60 calendar days after the disenrollment effective date>.

When can I get Part D 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 < PDP name >'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.

Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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 Part D 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.

For more information:
If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free 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 Prescription Drug Plan

<Date>

Dear < Member>:

Medicare has disenrolled you from <Part D plan sponsor 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 prescription drug coverage. Since the disenrollment has already happened, 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.

This decision was made by Medicare, not by <Part D plan sponsor 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 had an emergency or unexpected situation that kept you from paying your premiums on time. If Medicare approves your request, you will have to pay all Part D-IRMAA and plan premium amounts owed within three (3) months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) 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, you will not get your coverage back and will have to wait for another opportunity to enroll in a Part D plan. If you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare) , you may have to pay a Part D 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), 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 < Part D plan sponsor 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 21b: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Plan Premium Amount Due for Reinstatement

Referenced in section: 60.2.4

Dear <Name of Member>:

Medicare has notified us that you received a favorable decision on 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>.

This amount is due in addition to the amounts you owe <Medicare or RRB> for your Part D-IRMAA. You do not pay us your owed Part D-IRMAA amounts. <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.

[*PDP sponsors who include a payment 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.]

[*Sponsors 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 member number on the check.]

If we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>.

When can I get Part D 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 < PDP name >'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.

Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

For more information:
If you have any questions regarding the plan premium amount you owe and how you can pay, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 21c: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Plan Premium Amount Due for Reinstatement

Referenced in section: 60.2.4

Dear <Name of Member>:

We reviewed your request to get your coverage back, and your request has been approved. 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>**.

[PDP s*ponsors that include a payment 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.]

[PDP s*ponsors 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 we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>.

When can I get Part D 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 < PDP name >'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.

Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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 Part D 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. For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information:
If you have any questions regarding the plan premium amount you owe and how you can pay, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 21d: Model Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums

Referenced in section: 60.2.4

Dear <Name of Member>:

We reviewed your request to get your coverage back, and your request has been denied. This is because [I*nsert one of the following*: your request doesn't meet the criteria for reinstatement OR [*Insert if unable to make a decision based on the original request and unable to reach beneficiary*: we were not able to reach you to get the information needed to see if your circumstances meet the criteria for reinstatement.] This means you'll remain disenrolled from your plan. This decision is final, and can't be appealed.

You are still responsible for paying the plan premiums you owed at the time you were disenrolled.

When can I get Part D 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 < PDP name >'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.

Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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 Part D 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.

For more information:
If you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 21e: Model Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment

Referenced in section: 60.2.4

<Date>
<Beneficiary full name>
<Address>
<City, State Zip>

Dear <Member>:

We recently sent you a letter letting you know that we gave you a favorable decision on your request to get your coverage back.

The letter told you that in order to be reinstated into <plan name>, you had to pay all plan premiums you owe by <insert date 3 months after disenrollment effective date>. The amount owed was <$ insert total premium amount owed>. The letter also told you that if we didn't get full payment by the deadline, you would stay disenrolled [*insert if Part D coverage included in plan*: and you would not have Medicare prescription drug coverage].

Your Payment Wasn't Received on Time

Because you didn't pay the full amount you owe by the deadline, you will stay disenrolled from your Medicare Prescription Drug plan. This decision is final and can't be appealed.

You are still responsible for paying the plan premiums you owed at the time you were disenrolled.

When can I get Part D 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 < PDP name >'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.

Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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 Part D 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.

For more information:
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>.

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 21f: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement)

Referenced in section: 60.2.4.1

<Member # >

RxID
RxGroup
RxBin
RxPCN

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been approved. Our records show that we received the plan premium you needed to pay in order for your coverage to be reinstated.

We have updated our records to show that you are enrolled in <plan name> with no break in coverage. We will ask Medicare to correct its records to show the same.

You should continue to fill your prescriptions at <PDP name> network pharmacies.

If you have any questions about your plan premium and how you can pay, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you for your continued membership in <plan name>.

Exhibit 22 - Model Acknowledgement of Request to Cancel Enrollment Request

Referenced in section: 60.1.1

<Date>

Dear < Member>:

As you requested, we have cancelled your request to enroll with < PDP name >.

IMPORTANT: If you were enrolled in another Medicare Prescription Drug Plan or a Medicare Health Plan (such as a Medicare HMO or PPO) before enrolling with < PDP 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.

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. Generally, you may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'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.

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.

Please remember that if you don't have or get prescription drug coverage that is at least as good as Medicare's (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.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 22a - Model Confirmation of Reinstatement

Dear <member name>:

Please be sure to keep this letter for your records.

Medicare has enrolled you back in <plan name> with no break in coverage as of <effective date>.

You should keep using your <plan name> pharmacy for your health care.

[*Insert one of the following 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 23 - Model Acknowledgement of Request to Cancel Disenrollment Letter

Referenced in section: 60.1.2

<Date>

Dear < Member>:

As you requested, we have cancelled your disenrollment with < PDP name >. Thank you for your continued membership in our plan.

You should continue to fill your prescriptions at < PDP name > network pharmacies. If you use an out-of-network pharmacy, except in an emergency, < PDP name > may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

IMPORTANT: If you submitted an enrollment request to another Prescription Drug Plan or a Medicare Advantage Plan, you may appear on their records as being enrolled in their plan. Since you have told us you want to stay enrolled in < PDP name >, you will need to contact the other plan to ask them to cancel your enrollment before your enrollment takes effect. They may ask you to write them a letter for their records.

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. Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'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.

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 call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 24 - PDP Model Notice to Confirm Auto-Enrollment

Referenced in section: 40.1.4 (F)

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear <insert member name>

You are getting this letter because Medicare is enrolling you in our <PDP name>, and your coverage begins <effective date>. Medicare is also mailing you a yellow letter about your enrollment. Please keep both letters for your records.

[*Optional*: You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

What are my costs in this plan?
Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- $0 per month for your < PDP name > premium,
- $0 for your yearly prescription drug plan deductible,
- <insert applicable copay levels> when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <PDP name> at the number below.

What if Medicaid used to pay for my prescription drugs?
Remember, if Medicaid used to pay for your prescription drugs, Medicaid won't continue to cover the drugs it used to. Some state Medicaid programs may cover the few prescriptions that won't be covered under Medicare prescription drug coverage. But even if your state Medicaid program covers a few prescriptions, this coverage alone won't be as good as Medicare's (also referred to as "creditable coverage"). To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>.

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. You can also visit www.humana.com/pharmacists.

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 a Medicare drug plan.** 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 are not required to be in our Medicare prescription drug plan. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join.

If you don't want Medicare prescription drug coverage at all, call <PDP 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>. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 25 - PDP Model Notice to Confirm Facilitated Enrollment

Referenced in section: 40.1.4 (F)

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

Dear < member >

You are getting this letter because Medicare is enrolling you in our <PDP name> and your coverage begins <effective date>. Medicare is also mailing you a green letter about your enrollment. If you want coverage to begin earlier, you must tell us by <last day of month that is two months earlier than effective date>.

[*Optional*: You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

What are my costs in this plan?
Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert applicable deductible> for your yearly prescription drug plan deductible,
- <insert copay amount or 15% coinsurance> when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please call <PDP name> at the number below.

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 a Medicare drug plan.** 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 you 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 may 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. 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 are not required to be in our Medicare prescription drug plan. If you want to join a different Medicare prescription drug plan, simply call that plan to find out how to join.

If you don't want Medicare prescription drug coverage at all, call <PDP 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>. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 25b: Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015)

Referenced in section: 60.1.4

<Date>

Dear <name of applicant>:

Medicare has told us that you have canceled your enrollment in < PDP name> effective <insert date of enrollment that was canceled>. If this information is wrong, and you want to stay a member of our plan, please contact us.

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.

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 Medicare health or prescription drug 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 26 - PDP Acknowledgement of Request to Decline or Opt-Out of Part D Prior to Effective Date

Referenced in section 40.1.4 (G)

<Date>

Dear < Member>:

As you requested, < PDP name > has processed your request to decline (opt-out of) Medicare prescription drug coverage. Your decision to decline Medicare prescription drug coverage doesn't affect your enrollment in Medicare Part A or Part B. **If you have drug coverage through Medicaid (Medical Assistance), that program will no longer pay for your prescription drugs.**

Remember, like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy.

[Our records show that you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.] 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 decide you would like to join, please contact < PDP name > at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or visit www.medicare.gov. TTY users should call 1-877-486-2048

Thank you.

Exhibit 26a - PDP Acknowledgement of Request to Disenroll from PDP and Opt-Out of Part D After Effective Date

(Referenced in section 40.1.4 (G)

<Date>

Dear < Member>:

As you requested, < PDP name > has processed your request to disenroll from (opt-out of) Medicare prescription drug coverage. Your decision to disenroll from Medicare prescription drug coverage doesn't affect your enrollment in Medicare Part A or Part B. Your disenrollment from <PDP name> is effective <effective date>. After this date, < PDP name> will no longer pay for your prescription drugs. **If you previously had drug coverage through Medicaid (Medical Assistance), that program will no longer pay for your prescription drugs.**

Remember, like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy.

[Our records show that you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.] 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 decide you would like to remain in our plan, please contact < PDP name > at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or visit www.medicare.gov. TTY users should call 1-877-486-2048

Thank you.

Exhibit 27 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region

Referenced in section: 50.2.1.4

<Member #>
<RxID>
<RxGroup>
<RxBin>
<RxPCN>

<Date>

Dear < Member>:

You recently told us that you live in <state>. To make sure that you have Medicare prescription drug coverage where you live, we are enrolling you in <PDP name> that serves <insert states in the new plan's region>. Your new coverage will begin < effective date>.

If you disagree with the information in this letter or if you have any questions, please call <PDP name> at the phone number provided at the end of this letter.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert applicable deductible> for your yearly prescription drug plan deductible,
- <insert applicable copayments] when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <PDP name>.

You aren't required to be in <PDP name>. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join. You can also call 1-800-MEDICARE (1-800-633-4227, which is open 24 hours a day, 7 days a week) or visit www.medicare.gov on the web to choose and join a plan in your area that meets your needs. TTY users should call 1-877-486-2048.

If you have any questions, please call our <Customer Service, Member Services> department at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 28 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor DOES NOT offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region

Referenced in section: 50.2.1.4

<Date>

Dear < Member>:

You recently told us that you live in a place where we don't provide a Medicare prescription drug plan with premiums fully covered by extra help. You must live in <insert states where current PDP is offered> to be enrolled in <PDP name>. We have asked Medicare to disenroll you from < PDP name > beginning <effective date>.

It is important for you to call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) to choose and join a plan that serves your state or territory. TTY users should call 1-877-486-2048. If you want to learn about other Medicare prescription drug plans in your area that you can join, call 1-800-MEDICARE or visit www.medicare.gov.

If you disagree with the information in this letter or if you have any questions, please call customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 29 - Model Reassignment Confirmation

Referenced in section: 40.1.5 (E)

<Member #>
<RxID>
<RxGroup>
<RxBIN>
<RxPCN

Dear < member >

You are getting this letter because Medicare has enrolled you in <PDP name> for coverage beginning January 1, <following calendar year>. You should have already received a blue letter from Medicare telling you that they were moving you from the drug plan you were originally assigned to because either 1) that plan was leaving the Medicare program on December 31, <current calendar year>, or 2) the cost for that plan was increasing beginning January 1, <following calendar year>.

As of January 1, <following calendar year>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us**.**]

Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- <insert $0 per month for your <PDP name> premium, [for LIS individuals with 100% premiums subsidy] OR
- <insert applicable amount per month> for your <PDP name> premium, [for LIS individuals with premium subsidy other than 100%],
- <insert applicable deductible> for your yearly prescription drug plan deductible,
- <insert applicable LIS copay/coinsurance amount that will be charged in following calendar year> when you fill a prescription.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact customer service.

You aren't required to be in <PDP name>. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join. If you don't want Medicare prescription drug coverage at all, call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days/times> 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 30 - Optional Notice for "Losing Plan" to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC)

Referenced in section: 40.1.5 (E)

Dear < Member>:

Recently Medicare sent you a blue letter telling you that they will switch you to another Medicare drug plan starting January 1, <following calendar year>. This is because it will cost you more if you stay in <PDP name>.

The letter also said that you can stay in <PDP name> in <following calendar year>. However, if you stay with us, you will pay a higher monthly premium in <following calendar year>. If you want more information to help you decide, please call our <PDP name> <days and hours of operation>, at <customer service toll-free number>. TTY users should call <TTY number> for the hearing impaired. We will send you more information about the following:

- How your monthly premium would change for <following calendar year>
- How your benefits and costs would change for <following calendar year>
- What to do if your drug in <following calendar year> is no longer on the formulary or is more expensive

If you would like this information to help you decide or if you want to stay in <current plan>, call and let us know as soon as possible.

You can also get information about the Medicare Program and Medicare drug plans by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare customer service representatives are available, 24 hours a day, seven days a week, to answer questions about Medicare.

If you do nothing, your membership with us will end on December 31, <current calendar year>**. You will get information from your new plan telling you about your benefits and any costs for <following calendar year>.**

If you have any questions, please call customer service at <toll-free number><days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 31 - Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes

[Member **#]**

<Date>

Dear < Member>:

Your enrollment in <PDP name> has been updated.

[*Insert one or more of the following, including sufficient detail, to describe the specific enrollment change:*

- You have been enrolled in <PDP name>. Your coverage will start on <*start date*> and will end on <*end date*>. [*Insert information about premiums, if applicable, and how to access coverage, etc*.].
- Your enrollment in <*old PBP name*> has been changed to <new PBP name>. Your coverage in <*new PBP name*> 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 accessible and clear*].
- Your enrollment in <PDP n*ame*> started on an earlier date. Your coverage will start <*date*>. [*Include information about premiums and coverage here*]
- Your enrollment in <PDP n*ame*> has been changed to start on a later date. Your coverage with <PDP n*ame*> will start on < *date*>. [*Insert information about refunding premium, where applicable, and impact to paid claims*]
- Your enrollment in <PDP n*ame*> ended on < *date*>. This means you won't have coverage from <PDP n*ame*> 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 <PDP n*ame*> has been cancelled. This means that you don't have coverage from <PDP n*ame*>. [*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*.]

Call <PDP name> at <toll-free number> <days and hours of operation> if you have any questions or want more information. TTY users should call <toll-free TTY number>.

Did you know that people with limited incomes may qualify for extra help to pay for their Medicare 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 32 - Model Employer/Union Sponsored Prescription Drug Plan Group Enrollment Mechanism Notice

<Date>

Dear (name)

<Name of Employer or Union> is enrolling you in <name of PDP> as your retiree prescription drug plan beginning <effective date>, unless you tell us by <insert date no less than 21 days from the date of notice> that you don't want to join our plan. <Plan name> is a Medicare Prescription Drug (Part D) plan. This enrollment will automatically cancel your enrollment in a different Medicare Prescription Drug (Part D) plan or a Medicare Advantage plan. Please call us if you think you might be enrolled in a different Medicare Prescription Drug plan or a Medicare Advantage plan.

What do I need to know as a member of <PDP name>?
This mailing includes important information about <PDP name> 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 prescription drug plan, you don't have to do anything, and your coverage will start on <effective date>.

Once you are a member of <PDP 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 <PDP name> when you get it to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

<PDP Name> is a Medicare drug plan and is in addition to your coverage under Medicare Part A or Part B. Your enrollment in <PDP name> doesn't affect your coverage under Medicare Part A or Part B. It is your responsibility to inform <PDP name> of any prescription drug coverage that you have or may get in the future. You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, your enrollment in <PDP name> will end that enrollment. Enrollment in <PDP plan> is generally for the entire year.

By joining this Medicare prescription drug plan, you acknowledge that <PDP Name> will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <PDP Name> will release your information, including your prescription drug event data, 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 <PDP 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 drug plan. You can call 1-800-MEDICARE (1-800-633-4227) 24 hours per day, 7 days per week for help in learning how. TTY uses should call 1-877-486-2048. 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>.

What should I do if I don't want to join <PDP name>?
To request not to be enrolled by this process <insert clear instruction for opting out, including telephone numbers and days/hours of operation>.

What if I want to leave <PDP name>?
Medicare limits when you can make changes to your coverage. You may leave this plan only at certain times of the year or under certain special circumstances. To request to leave, call <PDP name>.

<PDP name> serves a specific area. If you move out of the area that <PDP Name> serves, you need to notify us so you can disenroll and find a new plan in your area.

Keep in mind that if you leave our plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

If you have any questions, please call customer service at <toll-free number><days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 33: PDP 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 inside 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 12 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 12 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. Don't 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. Don't 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: _____
Current Phone Number: _____

If you have moved and haven't told the Social Security Administration (SSA) about 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 the <Customer Service, Member Services> phone number listed above.

Thank you.

Exhibit 34: PDP Model Notice for Disenrollment Due 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 12 consecutive months.

Our records show that you haven't 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 your prescription drugs.

This letter pertains only to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits aren't affected by your disenrollment from < PDP name >.

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 Prescription Drug Plan that serves the area where you now live. You may 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) for information about plans that may serve your area.

If you don't enroll in a Medicare Prescription Drug 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 Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO). **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 if you want to join a plan in your area with a 5-star rating or you qualify for extra help in paying for your prescription drug costs.

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.

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 35 – PDP Notice of Disenrollment Due to 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 12 consecutive months. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.** Beginning <effective date>, <plan name> won't cover your prescription drugs.

This letter pertains only to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits aren't affected by your disenrollment from < PDP name >.

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 Prescription Drug Plan that serves the area where you now live. You may 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) 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 Prescription Drug 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 Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO). **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 if you want to join a plan in your area with a 5-star rating or you qualify for extra help in paying for your prescription drug costs.

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/Railroad Retirement Board benefit check?
If your Medicare Part D premium is being deducted from your Social Security or Railroad Retirement Board benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security/the Railroad Retirement Board within 3 months of this letter, you should contact 1-800-MEDICARE.

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 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.

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: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration

Referenced in section: 50.2

<Date>

Dear <Beneficiary Name>:

Medicare has disenrolled you from <plan name> because its records show that you are incarcerated. As of <effective date>, you no longer have coverage through <plan name>. Your Medicare prescription drug coverage ends on this date. You will have Original Medicare; however, Medicare generally doesn't pay for your hospital or medical bills if you're incarcerated.

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, based on information from SSA, not by <plan name>.

What if I think there's been a mistake?
If you aren't incarcerated or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

What happens to my Medicare and Part D coverage?
While you are incarcerated, you are not eligible to enroll in a Medicare health or Part D plan. However, once you are released and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. *This opportunity begins the month you are released and lasts for two additional months.* If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start 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 want to join a plan in your area with a 5-star rating, or you qualify for extra help with your prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after your release, you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

Who can I call to get more information?
You can call Social Security at 1-800-772-1213, if you have questions about your incarcerated status. TTY users should call 1-800-325-0778. If you have questions about your Medicare coverage, you can 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. You can also call < plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 37: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence

Referenced in section: 50.2, 50.2.7

<Date>

Dear <member name>:

Medicare has disenrolled you from <plan name> because the Social Security Administration (SSA) reported that you are not lawfully present in the United States. As of <effective date>, you no longer have coverage through <plan name>. Your Medicare prescription drug coverage ends on this date. You will have Original Medicare; however, Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S.

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, based on information from SSA, not by <plan name>.

What if I think there's been a mistake?
If you aren't unlawfully present in the U.S. or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

What happens to my Medicare and Part D coverage?
While you are unlawfully present in the United States, you are not eligible to receive any coverage in the Medicare program. This includes coverage through Original Medicare, a Medicare health plan or Medicare prescription drug coverage. If you become lawfully present in the U.S. in the future and report it to SSA*, you will have a special opportunity to join a Medicare health or Part D plan. This opportunity begins the month you regain lawful presence status and last for two additional months.* If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start 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.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after you become lawfully present in the U.S., you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

Who can I call to get more information?
You can call Social Security at 1-800-772-1213, if you have questions about your lawful presence status. TTY users should call 1-800-325-0778. If you have questions about your Medicare coverage, you can 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. You can also call < plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.