

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850



## **CENTER FOR DRUG AND HEALTH PLAN CHOICE**

**TO:** All PDP, MA-PD, MA, CCP, PFFS, RPPO, MSA, HCPPs,  
Employer/Union-Only Group Waiver Plans (EGWP) and Cost-Based  
Organizations

**FROM:** Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data  
Group, and Teresa DeCaro, RN, M.S., Acting Director, Medicare Drug & Health  
Plan Contract Administration Group

**DATE:** August 26, 2008

**SUBJECT:** Non-Renewal and Service Area Reduction Guidance, Timeline, and  
Model Final Beneficiary Notice Letters

This memorandum is to provide all PDP, MA-PD, MA, CCP, PFFS, RPPO, MSA, HCPPs, EGWP and cost-based organizations with guidance regarding their obligations to adhere to all CMS requirements and ensure that all affected beneficiaries receive timely notification of a non-renewal or service area reduction of their current plan for CY2009.

The combined timeline and guidance that follow are applicable to all Part C, Part D, EGWPs and cost-based organizations. At this time, the deadline has passed for organizations to submit a notice to voluntarily non-renew or to request a service area reduction. Similarly, the bid deadline has passed and CMS has sent a non-renewal or service area reduction acknowledgment e-mail to any organization that has failed to bid or has requested a non-renewal or service area reduction. Also following are the Model Final Beneficiary Notification Letters. Please follow the instructions and use the model that is appropriate for your specific type of organization.

If you have additional questions, please contact the following:

For Part C or cost-based organization related questions - Lisa Littleaxe at [lisa.littleaxe@cms.hhs.gov](mailto:lisa.littleaxe@cms.hhs.gov).

For Part D organization related questions - Rochel Schnur at [rochel.schnur@cms.hhs.gov](mailto:rochel.schnur@cms.hhs.gov)

# Medicare Part C and D Non-Renewal Process for 2009

## *A. 2009 Part C and D Non-Renewal Calendar*

Below is a combined timeline that applies to all Part C, Part D, employer/union-only group waiver plans, and cost-based organizations. Please pay careful attention to the guidance provided that applies to your specific type of organization. Please note that the dates given here are subject to change. Organizations should continue to monitor the general applications timeline posted on the CMS website.

<b>CALENDAR – 2009 Part C and D NON-RENEWAL PROCESS</b>	
<b>2008</b>	<b>ALL DATES ARE SUBJECT TO CHANGE</b>
<b>August</b>  <b>August – date to be determined –</b> CMS to release a letter to all organizations informing them about the Special Election Period (SEP) for beneficiaries who need to switch plans because their current plan is either non-renewing, eliminating the PBP they are enrolled in, or undergoing a service area reduction for their area. <b>August 1 –</b> Deadline for CMS to inform currently contracted organizations of CMS' decision not to authorize a renewal of a contract for 2009. <b>August 30 –</b> Latest date for CMS to approve final beneficiary notification letter of non-renewal.	
<b>October</b>  <b>October 2 –</b> MA and MA-PD organizations must publish a CMS-approved public notice on non-renewal in one or more newspapers of general circulation in each community or county in their contract areas. * <b>October 2 –</b> Personalized final beneficiary notification letter must be received by the affected beneficiaries for all organization types except for cost-based organizations.* <b>October 2 –</b> Medicare cost-based contractors and cost-based organizations to submit a non-renewal or service area reduction notice to CMS. <b>October 13 –</b> CMS to issue an acknowledgement letter to all Medicare cost-based organizations that are non-renewing or reducing their service area.	

<p>*Non-calendar year EGWPs must ensure that this requirement is met 90 days before the beginning of the employer/union sponsor's plan year.</p>
<p><b>November</b></p> <p><b>November 3 -</b> Date by which personalized final beneficiary non-renewal notification letter must be received by cost-based organization enrollees.</p> <p><b>November - date to be determined -</b> CMS to issue "close out" information and instructions to all organizations that are non-renewing or reducing service area.</p>
<p><b>December</b></p> <p><b>December 2 -</b> Cost-based organizations must publish a CMS-approved public notice of non-renewal in one or more newspapers of general circulation in each community or county in their contract areas.</p>

## ***B. Notices and Letters***

### ***1. Final Notification Letter of Non-Renewal to Beneficiaries***

#### ***a. Delivery Deadline for Final Beneficiary Letter***

All MA, MA-PD, PDP, and EGWP beneficiaries affected by non-renewal must receive their final notification letter no later than October 2, 2008. All beneficiaries affected by non-renewal in cost-based plans must receive their letter no later than November 3, 2008. CMS strongly encourages organizations to use first class postage to assure that they meet this delivery deadline. Regardless of when the letters are mailed, all MA and MA-PD letters must be dated October 2, 2008 and all cost-based letters must be dated November 3, 2008 to ensure national consistency in the application of Medigap guaranteed issue rights to all beneficiaries. Note: EGWP sponsors non-renewing a non-calendar year plan with the plan year ending before December 31<sup>st</sup>, must ensure that the final beneficiary notification letter is received by affected beneficiaries at least 90 days before the plan year end date.

#### ***b. Content and Format for Final Beneficiary Notification Letter***

The Model Final Beneficiary Notification Letters are at the end of this guidance. Please choose the letter that applies to your type of organization.

CMS will no longer prepare the "State-Specific" Model Final Beneficiary Notification Letter that MA organizations must use if they serve beneficiaries in one of the 24 states that have certain special Medigap protections beyond Federal law requirements. These states are California, Colorado, Connecticut, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan,

Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Washington, and Wisconsin. Instead, CMS will advise our SHIP partners so that they can provide the appropriate state specific Medigap information when they are contacted by beneficiaries.

MA and cost-based organizations **cannot** include information about their own Medicare supplemental policies in the body of the final notification letter. However, information on their Medicare supplemental policies may be mailed in the same envelope as the final notification letter.

EGWPs may customize the Model Final Beneficiary Notification Letter to the extent that modifications will more clearly and accurately reflect the benefits available to EGWP enrollees. The final notification letter, for both Part C and Part D, may be up to 15 pages long and should be printed on 8 1/2" x 11" paper and mailed in a similarly sized envelope. The letter must be individualized to enable affected beneficiaries to prove their special rights to Medigap insurers and other Medicare health organizations.

*c. Information on Alternative Choices for both MA and Cost-Based Organizations*

Finally, in accordance with 42 CFR 422.506(a)(2)(ii), CMS will allow affected MA and cost-based organization access to a new module within HPMS so that each non-renewing MA Organization can access a list of Medicare health plan organizations (MA and Medicare cost-based organizations), if any, that will be available to affected beneficiaries as alternative choices in 2009. MA and cost-based organizations must include this list of "remaining health organizations" as an attachment in the final notification letters, including those health organizations that have CMS-approved capacity limits. The letter must call special attention to the fact that MA and cost-based organizations may have different open enrollment cycles. The final notification letter should suggest that beneficiaries contact these Medicare health organizations to learn whether these organizations are accepting new members and to discuss their open enrollment dates. Under separate cover, CMS will inform Part C, Part D and cost-based organizations that remain in the Medicare program for 2009 of their responsibilities regarding non-renewal activity in the area and the Special Election Period (SEP).

Further instructions on how to access the list of remaining health organizations will be provided in the future.

*d. CMS Regional Office Review*

Except as provided below, all final beneficiary notification letters, including those based on the Model Final Beneficiary Notification Letters must be reviewed and approved by the appropriate CMS Regional Office (RO) prior to release. The final notification letter is not subject to the 10-day rule for marketing material review, but the RO will give priority to the final notification letters. CMS strongly suggests that all organizations use the provided models with as few changes as possible to expedite the review process. If the model is used, CMS expects RO

review and approval in 5 to 10 business days. *All final notification letters based on the model should be submitted in time for the review to be completed before August 30, 2008.* Organizations should consider this review period when they make plans to meet the October 2, 2008 deadline for MA, MA-PD, and PDP organizations and the November 3, 2008 deadline for cost-based organizations to ensure timely delivery of final notification letters to beneficiaries.

CMS has waived the prior review and approval requirements for all EGWPs. Therefore, EGWPs are not required to submit or receive approval of their final beneficiary notification letters from CMS RO staff.

#### *e. Medigap Information*

##### *(Guidance below for Cost and MA Organizations)*

Non-renewing MA organizations must inform all of their Medicare beneficiaries, including those who are eligible for Medicare due to a disability and individuals with End Stage Renal Disease (ESRD), of the obligations of Medigap issuers. Full information on this topic is provided in the Model Final Beneficiary Notification Letter, and the "State Specific" information can be received by contacting your local SHIP office. The model language will ensure accurate communication of these provisions.

##### *(Guidance below for MA and MA-PD organizations)*

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing MA plans in order to choose from a broader range of Medigap policies available on a guaranteed issue basis. MA organizations must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is made for a December 31, 2008, effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to purchase certain Medigap policies on a guaranteed issue basis. CMS Model Letters for Voluntary Disenrollment are found in the Medicare Managed Care Manual, Chapter 2, on CMS' website at <http://www.cms.hhs.gov/MedicareMangCareEligEnrol/Downloads/MAEnrollmentGuidanceUpdate.pdf>.

##### *(Guidance below for Cost-Based Organizations)*

Medicare cost-based organizations are required to provide or arrange for supplemental coverage of benefits related to a pre-existing condition with respect to any exclusion period for all Medicare beneficiaries age 65 or older. For beneficiaries under age 65 who are entitled to Medicare due to a disability or End Stage Renal Disease (ESRD), the cost-based organization must arrange for supplemental coverage if it is available in the marketplace. Please see §1876(c)(3)(F) and under CMS (HCFA) Medicare Cost Plan contract provision, Article IV, General Conditions, item R.

CMS regulations do not require provision of "Guaranteed Issue" (i.e., no medical screening, or coverage of pre-existing conditions) Medigap policy, if such a policy is not available in the marketplace. If Medigap issuers in a particular state do not sell Medigap policies to beneficiaries

who are eligible for Medicare due to a disability, the Medicare Cost-Based organization must provide supplemental coverage for pre-existing conditions.

The Medicare Managed Care Manual (CHAPTER 17) Section 3004.5(A) (2) (entitled "Provide Services Directly"), states that the Cost-Based organization "may directly provide or arrange for the provision of services related to pre-existing conditions with no charge to the beneficiary." The terms of the Agreement signed by Medicare cost-based organizations also refers to the requirement that, should the Cost-Based organization non-renew, it must provide or arrange for supplemental coverage for Medicare benefits related to a pre-existing conditions with respect to any exclusion period for "the lesser of six months or the duration of such period." See language at Article IV.R.

NAIC and HIPAA define "pre-existing conditions" as those "limited to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in a plan or policy."

CMS's interpretation is that coverage for pre-existing conditions for the disabled is a requirement whether a disabled beneficiary: 1) applies for and obtains a Medigap policy with a pre-existing condition exclusion; or 2) applies for and is denied coverage under a Medigap policy. Individuals who are eligible for Medicare due to age have similar protections. The beneficiary will still need to be provided coverage for pre-existing conditions, even if the Cost-Based organization has to provide such coverage directly. CMS believes that an individual who is eligible for Medicare due to a disability must make an attempt to obtain a Medigap policy before the cost-based organization can be required to provide coverage directly. The Medicare Cost-Based organization will not be required to provide coverage for pre-existing conditions for those members (aged and disabled) who do not seek a Medigap policy.

Coverage for pre-existing conditions is limited to those costs related to the pre-existing condition that results in Medicare cost-sharing amounts, such as Part A and B deductibles and coinsurance and excess part B charges, up to the limiting charge.

The Medicare Cost-Based organization may require all disabled members go to its physicians for treatment, during the time the organization is providing coverage for the pre-existing condition. The Cost-Based organization must coordinate and track these beneficiaries during the enrollment period and during the time they are receiving services. CMS must be able to track compliance.

Special rules apply for affected beneficiaries in a managed care trial period. These individuals must actively and voluntarily disenroll from their non-renewing Medicare cost-based organizations in order to choose from a broader range of Medigap policies available on a guaranteed issue basis. Medicare cost-based organizations must provide these beneficiaries with written documentation of their voluntary disenrollments, even if the voluntary request is for a December 31, 2008 effective date. Beneficiaries may be required to submit this written documentation to a Medigap issuer as proof of their right to buy certain Medigap policies on a guaranteed issue basis. CMS Model Letters for Voluntary Disenrollment are found in the Medicare Managed Care Manual, on CMS' website at

<http://www.cms.hhs.gov/MedicareMangCareEligEnrol/Downloads/MAEnrollmentGuidanceUpdate.pdf>.

*f. Public Notice of Non-Renewal for both MA, MA-PD and Cost-Based Organizations*

Non-renewing MA and MA-PD organizations must publish a public notice of non-renewal at least 90 days prior to the end of the contract year (i.e., no later than October 2, 2008). Non-renewing cost-based organizations must publish a public notice at least 30 days prior to the end of the contract (i.e., no later than December 2, 2008). The publication of the public notice must be in one or more newspapers of general circulation in each community or county in the non-renewing contract areas. CMS will provide a Model Public Notice of Non-Renewal for all organizations. MA and cost-based organizations that use the CMS Model Public Notice of Non-Renewal without revision are not required to submit the notice to their CMS ROs for review and approval prior to release. However, these MA and cost-based organizations must inform their ROs of the date the notice will be published and, within 5 days after publication, submit a photocopy or clipping of the notice(s) containing the name of the newspaper(s) and publication date. CMS will enter the date of the public notice in the HPMS system.

MA and cost-based organizations that revise the CMS Model Public Notice of Non-Renewal must submit the notice to their RO for review and approval prior to its release for publication. CMS expects this process to take 5 business days. CMS encourages MA organizations to consider this review period when they make plans to meet the October 2, 2008 and/or the December 2, 2008 public notice deadline.

## **C. Systems Issues**

### **1. System and Enrollment Transaction Information**

Organizations should refer to the 2009 Call Letter for the exact systems and enrollment transaction information for each organizational type. Specifically, organizations must follow the instructions provided in Attachments G and H regarding whether or not the organization will have to submit transactions. Whenever it is necessary for the organization to submit transactions to reflect contract changes from year to year, the organization must first obtain approval from the CMS Division of Payment Operations (DPO) representative on content, timing and certain specific data elements prior to the submission of any transactions for these purposes. When a PDP sponsor that currently has multiple Plan Benefit Packages (PBPs) that each service different Part D Regions under a single contract number wants to reduce the number of Part D regions served under that contract, the PDP sponsor should follow the instructions in Attachment H to terminate the PBP that is not part of the next year's contract. For questions about system and enrollment transaction information please contact your organization's CMS account manager.

## *2. Partial County Service Area Reduction Requests for MA, MA-PD and Cost*

CMS has authority under its county integrity policy to approve limited exceptions to the principle of county integrity. The requirements for approving exceptions to the county integrity policy and documentation requirements can be found in Chapter 4 of the Medicare Managed Care Manual.

MA organizations must submit partial county requests to CMS for approval in accordance with current policy and CMS timeline for each year. Specifically, CMS will analyze demographic information to ensure a nondiscriminatory impact on excluded parts of a county or counties and excluded populations.

MA organizations should send requests to the appropriate Regional Office Account Manager with a copy to Central Office which must be received at CMS no later than May 1, 2008.

### ***D. “Close-Out” Information***

In the fall of 2008, CMS will provide a “close-out” letter to non-renewing organizations with complete details regarding their obligations after non-renewal. These instructions are to ensure that affected beneficiaries experience a smooth transition to another health coverage option and define those tasks that the organization must perform after the last day of its contract.



## PDP Model Beneficiary Non-Renewal or SAR Notification Letter

<DATE>

Dear <Member Name>,

<PDP Name> [(will not be renewing its Medicare Prescription Drug Benefit contract) or (will not be serving the following States: <Insert State Names>) or (will not be offering individual beneficiary coverage)] effective January 1, <Insert Upcoming Year> (*sponsor may insert “customized” language, subject to CMS review.*) This means you need to join a **new** Medicare drug plan by **December 31, <Current Year>**.

**Until your enrollment in <PDP name> ends, you should keep using <PDP name> network pharmacies to fill your prescriptions.**

We are including information to help you learn about your options for prescription drug coverage since <PDP Name> is ending. Remember in order to have a Medicare drug plan after December 31, <Current Year>, you need to choose another Prescription Drug Plan or Medicare Advantage Plan that offers prescription drug coverage.

[*For LIS members:* If you qualify for extra help (the low income subsidy) either from the State Assistance program or Social Security for <Current Year>, you will get a letter from Medicare offering to move you to a Medicare drug plan where you will pay little or no monthly premium in <Following Year>. You may also choose to join a different plan. Medicare will send you a letter with more information by early November. However, if you want to, you may join another plan before receiving this letter.]

### **How do I join a new Medicare drug plan?**

**The following information is intended to help you choose a new plan.**

Compare plans that are available and join one that meets your needs. Find out which plans cover the prescriptions you take and what pharmacies you can use to fill your prescriptions. The following resources are available to help you compare the costs and coverage of each plan:

- Call 1-800-MEDICARE (1-800-633-4227). **TTY users should call 1-877-486-2048.** This toll-free help line is available 24 hours a day, seven days a week, to answer your questions about Medicare and to take orders for Medicare publications. You can speak to a Customer Service Representative in English or Spanish. You can also get information about ways to help with your prescription drug and other health care costs.
- Visit [www.medicare.gov](http://www.medicare.gov) for step-by-step help with your Medicare prescription drug coverage options. TTY users should call 1-877-486-2048. This is Medicare’s official consumer website. Here are some of the tools you can use on this website to get quick answers to your questions:

- Medicare Prescription Drug Plan Finder – Look at and compare the prescription drug plan options in your area.
- Helpful Contacts – Get telephone numbers for local organizations that can answer your questions and links to other health websites.
- Call <Name of SHIP> at <SHIP Number(s)>. TTY users can call <SHIP TTY number>. *[Note to Part D sponsor: Your CMS Regional Office can provide the SHIP name and the telephone number(s) that should be used here.]* Volunteer health insurance counselors are available to answer your questions, discuss your needs, and give you information about your options.
- **Get a copy of the “Medicare & You” handbook or other Medicare publications.** The “Medicare & You” handbook provides information about your health care choices. The handbook is mailed to people with Medicare each October. The handbook is available in English, Spanish, Braille, large print (English and Spanish), or on audiotope (English and Spanish). Other helpful publications include “Choosing A Medigap Policy: A Guide To Health Insurance For People With Medicare” (CMS Pub. No. 02110) and “Your Guide to Medicare Prescription Drug Coverage” (CMS Pub. No. 11109). You can read or print out these publications at [www.medicare.gov](http://www.medicare.gov) on the web. Or, you can call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048.
- Call your State Medical Assistance Office at <State Medical Assistance Office Number>. Call to see if your state has a program for people with limited income and resources that pays Medicare premiums and, in some cases, Medicare deductibles and coinsurance. It is very important that you call if you think you qualify even if you aren’t sure. TTY users should call <State Medical Assistance Office> at <TTY Number>.
- Call the plan you are interested in joining to get information about the plan. Some plans will allow you to enroll over the telephone or through their own secure website. Contact the plan for more information.

Enroll early. Enrolling early in the month (before the 15<sup>th</sup>) gives the new Medicare drug plan time to mail you a membership card, acknowledgement letter, and welcome package before your new coverage becomes effective. This way, you can get your prescriptions filled without delay, if you go to the pharmacy on the first day your new coverage begins. You may want to ask your family, friends or other people you trust for help in making this decision. However, be sure the recommended plan will cover your prescriptions. If you have employer or union prescription drug coverage, contact your employer or union and ask how enrolling in another plan will affect your employer or union benefits.

If you decide to join another Medicare drug plan, your coverage may start on November 1, <Current Year>, December 1, <Current Year>, January 1, <Following Year>, or February 1 <Following Year>, as long as the plan you want to join gets your application to join **before the start date you choose**.

## **What happens if I don't join another Medicare drug plan?**

Medicare limits when you can join a Medicare drug plan. If you don't join another Medicare drug plan by January 31, <Following Year>, your next chance to join will be from November 15 through December 31, <Following Year>. (In certain special circumstances, you may have another chance to join, such as if you qualify for extra help (the low income subsidy) or you are a resident of a nursing facility.)

**If you don't join another Medicare Prescription Drug Plan by the dates mentioned in this letter and you don't have other drug coverage that is at least as good as Medicare's, you may have to pay a penalty in your premium if you join later. This means you pay a higher premium for as long as you have Medicare prescription drug coverage.**

We apologize for any inconvenience this may cause you. If you need more information, please call our Member Services Department at <Phone Number>. You can speak to someone at this number, <Days & Hours>. You can also visit [www.medicare.gov](http://www.medicare.gov) on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. A Customer Service Representative will be able to answer your questions. Tell the Customer Service Representative that you got this letter.

Sincerely,

<PDP Sponsor representative>

**MA, MAPD or Cost Organization Model Beneficiary Non-Renewal or SAR Notification Letter**

DATE: <Insert Date-date  
can not be later than October 2, 2008>

Dear <member's name>,

<MA, MAPD or Cost Organization Name> will no longer offer <plan name> to people with Medicare in <County/State Name(s)> after <Date>. (*Organization may insert "customized" language, subject to CMS review.*) You will need to make some decisions about your health care coverage and prescription drug coverage. This letter provides information to help you learn about your Medicare health care options. Remember, you are still in the Medicare Program no matter what you decide.

[Non-network *PFFS* plans do not include this sentence, All other organization/plan types must include: **Until your membership in <plan name> ends, you must continue to use our network doctors and other health plan providers.**]

When coverage from <plan name> ends after <Date>, your Medicare prescription drug coverage ends too. In order to have new health care coverage and prescription drug coverage after <Date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action, as described in this letter. For example, if you are joining another Medicare Advantage plan and you want to continue drug coverage, then you need to select a plan with Medicare prescription drug coverage. If you are returning to original Medicare coverage and you want to receive Medicare prescription drug coverage, then you must join a Medicare prescription drug plan.

[*For LIS members:* If you qualify for extra help (the low income subsidy) for 2009, and you do not join a Medicare drug plan on your own, Medicare will enroll you in a Medicare drug plan where you will pay little or no monthly premium in 2009. However, you don't need to wait until you get this letter if you want to join a new plan.]

Before you make a decision about your health care coverage, you should do these things:

1. If you have an employer or union group health care plan, contact your employer or union.
2. If you get help from the Medicaid program, contact <State Medicaid Agency> to confirm your understanding of how your Medicaid coordinates with a new plan and/or Original Medicare.
3. Read the attached information to learn more about
  - Your health plan choices including Medicare prescription drug coverage (**section 1**);
  - Your choices to join Original Medicare and to buy a Medigap policy (**section 1**);

- Your options if you have permanent kidney failure, also known as End-Stage Renal Disease (ESRD) (**section 2**) (*omit if no ESRD members*);
- Your choices if you only have Medicare Part B (**section 3**) (*omit if no Part B only members; renumber if section 2 is omitted*); and 2009 MA-PD & MA Only Non Renewal Letter
- Where to get answers to your questions and help making a decision (**section 4**). (*renumber if sections 2 and/or 3 are omitted*)

4. **Keep this letter.** It is proof that you have a special right to buy a Medigap policy [*include the following only if other MA plans available: or you can join a new Medicare Advantage plan*].

We apologize for any inconvenience. If you need more information, please call our Member Services Department at <Phone Number> <Days & Hours>. For TTY/TDD users should call <insert number > and the hours of operation are <Days & Hours>. You can also visit [www.medicare.gov](http://www.medicare.gov) on the web or call 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048. A Customer Service Representative will be able to answer your Medicare and Medigap questions. Tell the Customer Service Representative that you got this letter.

Sincerely,

<CEO or other official of MA organization>

Enclosure

**Section 1: What are My Health Care and Prescription Drug Coverage Choices?** [*Note: Include only those options that apply and renumber remaining options and page references accordingly*]

Health Care Options See Page(s)	See Page(s)
Option 1: You can join another Medicare Advantage or Other Medicare Health Plan, including a plan that offers prescription drug coverage.	1
Option 2: You can change to the Original Medicare Plan and join a Medicare Prescription Drug Plan.	2
Option 3: You can change to the Original Medicare	3-5

Plan, you may buy a Medigap (Medicare Supplement Insurance) Policy, and join a Medicare Prescription Drug Plan.

Option 4: You can change to the Original Medicare Plan and use other health care and prescription drug coverage, such as an employer or union group health care plan, VA benefits, or TRICARE for Life. 5

After you review the following information, you may want to call 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) on the web for step-by-step help with your Medicare health care options. TTY users should call 1-877-486-2048. You can also call <name of SHIP> at <SHIP number> for help. TTY users should call <SHIP TTY number>.

### **Option 1: You Can Join Another Medicare Advantage or Other Medicare Health Plan, including a plan that offers Prescription Drug Coverage**

<MA plan name> is a Medicare Advantage Plan. You can enroll in another Medicare Advantage Plan or another Medicare Health Plan in your area. Most Medicare Health Plans are offered by private companies and can be Health Maintenance Organization plans (HMOs), Preferred Provider Organization plans (PPOs), or Private Fee-for-Service plans. If you like having a Medicare Advantage Plan, you may join another Medicare Advantage Plan with another company. Most, but not all, Medicare Advantage Plans include prescription drug coverage.

If you are eligible, you can join another Medicare Advantage Plan that starts on November 1, December 1, 2008, and January 1, 2009 or February 1, 2009 , as long as the plan you want to join gets your request to join **before the start date you choose.**

There are other available Medicare health plans similar to this one. They are listed in the attached table at the end of this letter. These plans may have different rules than our plan, such as when you can join, when your coverage begins, where you can go for your health care or which providers you can access for your health care. For example, in order to enroll in a Medicare Advantage Plan, you must have Medicare Parts A (hospital insurance) **and** B (medical insurance). [Note to MAO- if a cost plan choices(s) exist, add the following paragraph] There are also exceptions to this

rule for “cost plans”. You may be able to join a cost plan, even if you don’t have Medicare Part A. If you are interested in joining a cost plan, you should call the plan to see what the requirements are.

To see which plans include prescription drug coverage, you can call 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) on the web. TTY users should call 1-877-486-2048. For help comparing the companies that offer Medicare Health Plan in your area, call 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) on the web. TTY users should call 1-877-486-2048.

## **Option 2: You Can Change to the Original Medicare Plan and join a Medicare Prescription Drug Plan**

This is the Original Medicare Plan that is available nationwide. You can go to any doctor or specialist that accepts Medicare and is accepting new Medicare patients, and to any hospital or other facility. You don’t need a referral. The Federal Government manages the Original Medicare Plan.

If you decide you want Original Medicare Plan coverage **beginning January 1, 2009**, you don’t need to do anything. Medicare will automatically change you to the Original Medicare Plan on January 1, 2009 .

If you decide you want Original Medicare Plan coverage **before January 1, 2009**, you can do one of the following:

- Send or fax us a written request saying you want to leave our plan, or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Tell the Customer Service Representative that you want to leave <MA plan name> and begin receiving health care coverage from the Original Medicare Plan.

If you decide to leave < plan name> before January 1, 2009, you can select when your Original Medicare Plan coverage starts. Your coverage may start on November 1 or December 1, 2008, as long as your request to join is received **before the start date you choose**. As mentioned above, you don’t need to do anything if you want Original Medicare Plan coverage to start on January 1, 2009.

If you choose to leave our plan before December 31, 2008, and don’t select when your Original Medicare Plan coverage starts, we will let you know, in writing, what date your new Original Medicare Plan coverage begins. You will get your health care from the Original Medicare Plan the day after your enrollment with our plan ends.

## IMPORTANT -- If You Currently Have Medicare Prescription Drug Coverage Through a Separate Company

If you already have a Medicare Prescription Drug Plan from another plan, your disenrollment from our plan will not impact your enrollment in your drug coverage. Effective January 1, 2009, you will be in the Original Medicare Plan and your prescription drug coverage that you have will continue.

However, if you choose to enroll in another Medicare Advantage plan that offers Medicare prescription drug coverage, your enrollment in your current prescription drug plan will end.

If you want another Medicare drug plan, you should compare those available and join one that meets your needs. Find out which plans cover the prescriptions you take and what pharmacies you can use to fill your prescriptions. For help comparing the costs and coverage of each plan, call 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) on the web for step-by-step help with your Medicare prescription drug coverage options. TTY users should call 1-877-486-2048. You can also call <name of SHIP> at <SHIP number(s)>. TTY users can call <SHIP TTY number>.

## If You Want Prescription Drug Coverage

The Original Medicare Plan does not include Drug Coverage. To get drug coverage under Original Medicare you must join a Medicare Prescription Drug plan.

If you change to the Original Medicare Plan and want to get prescription drug coverage, you can join a Medicare Prescription Drug Plan. Medicare prescription drug coverage is available to everyone with Medicare. Private companies provide this coverage. Like other insurance, if you decide not to join when you are first eligible, you may pay a penalty if you choose to join later.

If you want a Medicare drug plan, you should compare those available and join one that meets your needs. Find out which plans cover the prescriptions you take and what pharmacies you can use to fill your prescriptions. For help comparing the costs and coverage of each plan, call 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov) on the web for step-by-step help with your Medicare prescription drug coverage options. TTY users should call 1-877-486-2048. You can also call <name of SHIP> at <SHIP number(s)>. TTY users can call <SHIP TTY number>.

If you join a Medicare drug plan, your coverage may start on November 1, December 1, 2007, January 1, 2009 or February 1, 2009, as long as the plan you want to join gets your request to join **before the start date you choose**.



**If you don't join a Medicare Prescription Drug Plan, and you don't have other drug coverage that is at least as good as Medicare's, you may have to pay a penalty if you join later. This means you pay a higher premium for as long as you have Medicare prescription drug coverage.**

### **Option 3: You Can Change to the Original Medicare Plan, Buy a Medigap (Medicare Supplement Insurance) Policy, and Join a Medicare Prescription Drug Plan**

#### **Understanding Medigap**

A Medigap policy, also called "Medicare Supplement Insurance," is a health insurance policy sold by private insurance companies. Costs that you must pay like coinsurance, copayments, and deductibles are called "gaps" in Original Medicare Plan coverage. You might want to consider buying a Medigap policy to help cover these gaps. Some Medigap policies also cover other benefits that aren't covered by Medicare like emergency health care while traveling outside the United States.

Since January 1, 2006, you can't buy new Medigap policies covering prescription drugs because private companies approved by Medicare now offer Medicare prescription drug coverage.

Coverage under a Medigap policy is different from the coverage you have under <plan name>. Since Medigap policies only help pay health care costs if you are in the Original Medicare Plan, you don't need to have a Medigap policy if you are in a Medicare Advantage Plan.

In most States, there are 12 standardized Medigap policies available. They are called Medigap Plans A through L. Each plan has a different set of benefits. Plans K and L are new policies that have higher out-of-pocket costs for certain benefits than Plans A-J. However, Plans K and L limit those out-of-pocket costs. Plans K and L will generally cost less than Plans A-J because they have higher out-of-pocket costs and provide fewer benefits.

It is important that you read this entire section to find out if you have Medigap rights and to understand your choices. If, after reading this section, you still have questions about your Medigap rights, call <name of SHIP>, your State Health Insurance Assistance Program at <SHIP number(s)>. <Name of SHIP> is a State program that gives free local health insurance counseling to people with Medicare.

If you change to the Original Medicare Plan, you may want to buy a Medigap policy. If you want to buy a Medigap policy, follow these basic steps:

1. Contact a private insurance company that sells Medigap policies and ask for an application.
2. Apply for a policy **before** your coverage under <MA plan name> ends so that your Medigap policy coverage starts the same day as your Original Medicare plan coverage. **If you wait until [MA plan name] ends to apply for a Medigap policy, you may incur a gap in coverage because the Medigap policy will not be effective immediately. In order to prevent a gap in coverage, apply while you are still enrolled in [MA plan name] and request that the Medigap policy coverage begins on the date [MA plan name] terminates. However, to protect your rights to buy a Medigap policy, you must apply for a Medigap policy no later than 63 calendar days after your coverage under <MA plan name> ends.** Your coverage under <MA plan name> ends on December 31, 2008, unless you ask to leave our plan before that date.
3. **Make a copy of the cover letter that came with this mailing and send that letter in with your Medigap application.** It will prove that you have special rights to buy a Medigap policy.

**Remember, you will have coverage under the Original Medicare Plan even if you don't buy a Medigap policy.**

### Your Rights to Buy a Medigap Policy

Usually, private insurance companies usually don't have to sell you a Medigap policy unless you are still in your Medigap open enrollment period. Your Medigap open enrollment period is usually the 6-month period that starts when you are age 65 or older **and** enrolled in Medicare Part B. If you are under age 65, you will get a 6-month open enrollment period when you turn age 65 **and** are enrolled in Medicare Part B. In addition to Medigap open enrollment rights, you may have special rights called Medigap protections or guaranteed issue rights when you lose your health insurance coverage or your health coverage changes. If you buy a Medigap policy, and you have guaranteed issue rights, the insurance company must sell you a policy, must cover pre-existing conditions, and can't charge you more because of any past or present health problems.

**Because you are losing coverage under <MA plan name> you may have a limited right to buy a Medigap policy.**

- **If you are age 65 or older:**

You have the right to buy Medigap Plan A, B, C, F, K or L from any company selling these policies in <State>. You can apply for a Medigap policy any time after the date of this letter. It is best to apply for a

Medigap policy **before** your coverage under <non-renewing MA plan> ends. To protect your rights, **you must apply no later than 63 calendar days after your coverage under our health plan ends.** Your coverage under <non-renewing MA plan> ends on December 31, 2008, unless you ask to leave our plan before that date.

- **In the following situations you may also have the right to buy other Medigap plans** in addition to Plan A, B, C, F, K or L:
  - you are age 65 or older and first got Medicare Part B in the last 6 months;
  - you dropped a Medigap policy within the past 12 (in some cases 24) months to join a Medicare Advantage Plan for the first time; or
  - you joined a Medicare Advantage Plan during the last 12 (in some cases 24) months when you were first eligible for Medicare Part A at age 65.
  - Some states require insurance companies to sell you other Medigap plans when your coverage under <name of plan> ends. Call the <name of SHIP> at <SHIP number> for more information about whether this applies in <State>.

If you think any of these situations apply to you, or if you are not sure, you should call <name of SHIP> at <SHIP phone number(s)> as soon as possible because **you must apply for a Medigap policy in a limited time period.**

- **If you are under age 65:**

You may not be able to buy a Medigap policy until you turn age 65. There is no federal law that says insurance companies must sell Medigap policies to people under age 65. However, some states require insurance companies to sell you a policy at certain times, even if you are under age 65. If an insurance company voluntarily sells Medigap Plan A, B, C, F, K or L to anyone with Medicare who is under age 65 in <State>, it must sell these plans to anyone whose Medicare Advantage plan will no longer provide Medicare services. Call the <name of SHIP> at <SHIP number> for more information about whether any Medigap policies are offered to people with Medicare under age 65 in <State>. It is best to apply for a Medigap policy **before** your coverage under <non-renewing MA plan> ends. To protect your rights, **you must apply no later than 63 calendar days after your coverage under our health plan ends.** Your coverage under <non-renewing MA plan> ends on December 31, 2008, unless you ask to leave our plan before that date.

You can apply for a Medigap policy any time after the date of this letter. Remember, it is best to apply for a policy **before** your coverage under [plan

name] ends so that your Medigap policy coverage starts the same day as your Original Medicare Plan coverage. However, to protect your rights, **you must apply no later than 63 calendar days after your coverage under our health plan ends.** Your coverage under [plan name] ends on December 31, 2008, unless you ask to leave our plan before that date.

**To find out more about your Medigap rights and to get help making a decision, call the <name of SHIP> at <SHIP phone number(s)>.**

If you change to the Original Medicare Plan, buy a Medigap policy, and want to get prescription drug coverage, you can join a Medicare Prescription Drug Plan. See Option 2, earlier in this notice, for information on joining a Medicare Prescription Drug Plan.

**Option 4: You can change to the Original Medicare Plan and use other health care and prescription drug coverage, such as an employer or union group health care plan, VA benefits, or TRICARE for Life.**

You may already have health care and prescription drug coverage such as an employer or union group health care plan, veteran's benefits, or military retiree benefits. You should call your insurer or benefits administrator to see if you might need additional coverage and how much it costs.

## **Section 2: What if I Currently Have Permanent Kidney Failure?**

*(include only if non-renewing plan has ESRD members)*

Different rules may apply to people with Medicare who have permanent kidney failure (also called End-Stage Renal Disease or ESRD). **If you don't have permanent kidney failure, skip to Section 3.**

If you have permanent kidney failure, you have a one-time right to join a new Medicare Advantage Plan. *(If other plans are available, insert: Available Medicare Advantage and/or Cost Plans are shown in Section 1. If no other plans are available, insert: Since there are no other Medicare Advantage and/or Cost Plans available in your area, you will get your Medicare covered benefits from the Original Medicare Plan.)* Save this letter as proof of your right to join a new Medicare Advantage Plan. If you change directly to the Original Medicare Plan after leaving <name of plan>, you will still have a one-time right to join a Medicare Advantage Plan at a later date as long as you are in an enrollment period.

*(Omit if no other plans are available)* If you join a new Medicare Advantage Plan and later choose to leave that plan, you won't be able to join another Medicare Advantage Plan. You will get your Medicare coverage from the Original Medicare Plan. The only way you may get another chance to join a new Medicare Advantage Plan is if the new plan you join later leaves the Medicare Program or stops providing care in your area.

### Section 3: What if I Only Have Medicare Part B? *(include only if non-renewing plan has Part B only members)*

#### **If you have both Medicare Part A and Part B, skip to Section 4.**

If you aren't sure if you have Medicare Part A and/or Part B, you can check the lower left corner of your red, white, and blue Medicare card. It will show which parts of Medicare you have. If you still aren't sure, call your local Social Security office or call the Social Security Administration at 1-800-772-1213.

If you want to join a new Medicare Advantage Plan or you want to buy a Medigap policy, you must have both Medicare Part A and Part B. If you currently have only Medicare Part B, you will have to enroll in Part A. If you want to enroll in Part A, you should call the Social Security Administration at 1-800-772-1213 or visit your local Social Security office to find out how much it will cost. The minimum amount you will pay for Part A is \$ <2008 premium amount> per month in 2008. *[Note: if 2009 amount available, repeat sentence with 2009 amount]*. This amount will change every year.

Note: If you get your Medicare coverage through an employer or union group health care plan, check with your benefits administrator to see if there is an exception to this rule.

*[Note to MA organizations—If cost plan choice(s) exists, add the following: "There are exceptions to this rule for certain types of Health Maintenance Organization (HMO) plans, called Medicare Cost Plans. You may be able to join a Medicare Cost Plan, even if you don't have Medicare Part A. If you are interested in joining, you should call the plan to see what the requirements are. <Name(s) of cost plan(s)> (is a Medicare Cost Plan) (are Medicare Cost Plans). Look in Section 1 under Option 1 for (<name of cost plan>'s phone number.) (the plans' phone numbers.)"]*

#### **When to Enroll in Medicare Part A**

If you enroll in Medicare Part A, you can enroll in October, November, or December 2008, or January 2009 . If you enroll during one of these months, your Part A coverage will begin January 1, 2009 , unless you say you want it sooner. You can also enroll from February 2009 through August 2009. If you enroll during one of these months, your Part A coverage will begin the month after you enroll. The Social Security Administration can give you information about t enrolling in Medicare Part A. You can visit your local Social Security office or call them at 1-800-772-1213. TTY users should call 1-800-325-0778.

If you don't enroll in Medicare Part A during the months specified above, you can still enroll from January through March of every year. If you enroll during these months, your Part A coverage will begin on July 1st of that same year. You can join another Medicare Advantage Plan at that time.

## Section 4: Where Can I Get More Information and Help with My Health Care and Prescription Drug Coverage Decisions?

- Visit [www.medicare.gov](http://www.medicare.gov) on the web

This is Medicare's official consumer website. Here are some of the tools you can use to get quick answers to your questions:

- Medicare Personal Plan Finder – Look at and compare the health plan options in your area.
- Helpful Contacts – Get telephone numbers for local organizations that can answer your questions and links to other health websites.

- Call **1-800-MEDICARE (1-800-633-4227)**  
**TTY users should call 1-877-486-2048.**

This toll-free help line is available 24 hours a day, seven days a week, to answer your questions about Medicare and to take orders for Medicare publications. You can speak to a Customer Service Representative in English or Spanish. You can also get information about ways to help with your prescription drug and other health care costs.

- **Get a copy of the “Medicare & You” handbook or other Medicare publications**

The “Medicare & You” handbook provides information about your health care choices. The handbook is mailed to people with Medicare each October. The handbook is available in English, Spanish, Braille, large print (English and Spanish), or on audiotape (English and Spanish). Other helpful publications include “Choosing A Medigap Policy: A Guide To Health Insurance For People With Medicare” (CMS Pub. No. 02110), “Your Guide to Private Fee-for-Service Plans” (CMS Pub. No. 10144), and “Your Guide to Medicare Prescription Drug Coverage” (CMS Pub. No. 11109). You can read or print out these publications at [www.medicare.gov](http://www.medicare.gov) on the web. Or, you can call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048.

- **Call <name of State Health Insurance Assistance Program (SHIP)> <SHIP number(s)>** *[Note: Your CMS Regional Office can provide the SHIP name and the telephone number(s) that should be used here.]*

Volunteer health insurance counselors are available to answer your questions, discuss your needs, and give you information about your options.

- **Call <name of State Insurance Commissioner's Office> at <appropriate phone number(s)>** *[Note: Your CMS Regional Office can provide the name and the telephone number(s) that should be used here].*

Call if you have questions about the Medigap policies available in your area.

- **Call your State Medical Assistance Office at <state Medical Assistance office number>**

Call to see if your state has a program for people with limited income and resources that pays Medicare premiums and, in some cases, Medicare deductibles and coinsurance. It is very important that you call if you think you qualify even if you aren't sure. TTY users should call <state Medical Assistance office> at <TTY number>.