Medicare Managed Care Manual

Chapter 2 - Medicare + Choice Enrollment and Disenrollment

Appendices and Exhibits

Last Updated - Rev. 26, 07-25-03

Table of Contents

Appendix 1: Summary of Notice Requirements (3 Pages)

(Rev. 26, 07-25-03)

Referenced in sections: 10,30, 40, 50, and 60

This Exhibit is intended to be a summary of notice requirements. For exact detail on requirements and time frames, refer to the appropriate sections within this Chapter.

Notice	Section	Required?	Timeframe
Individual Enrollment Form (Exh. 1)	10, 40.1, 40.2, 40.4.1	Yes	NA
EGHP Enrollment Form (Exh. 2)	10, 40.1, 40.2, 40.4.1	No	NA
Short Enrollment Forms (Exh. 3 and 3a)	10, 40.1, 40.2, 40.4.1	No	NA
Acknowledgment of Receipt of Completed Enrollment *Election* (Exh. 4 and 4a)	40.4.1, 60.4	Yes	Before effective date, or if late in election period, 7 business days of receipt of completed enrollment *election*
Request for Information (Exh. 5)	40.2.2	No	NA
Confirmation of Enrollment (Exh. 6 and 6*a*)	40.4.2, 40.6	Yes	7 business days of reply listing
M+CO Denial of Enrollment (Exh. 7)	40.2.3	Yes	7 business days of denial determination
CMS Rejection of Enrollment (Exh. 8)	40.4.2	Yes	7 business days of reply listing (one exception described in §40.4.2)
Sending Out Disenrollment Form/Disenrollment Form (Exh. 9-10)	50.1	No	NA
Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11)	50.1, 50.4.1	Yes	7 business days of receipt of written request to disenroll
Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)	50.1	No	NA

Notice	Section	Required?	Timeframe
Confirmation of Voluntary Disenrollment Identified Through Reply Listing (Exh. 12)	50.1, 50.4.1. 60.3.2	Yes	7 business days of reply listing
Verification of Change in Address (no exhibit)	50.2.1	No	NA
Disenrollment Due to Permanent Move (no exhibit)	50.2.1	Yes	Within 7 business days of learning of the permanent move and no later than before the disenrollment transaction is submitted to CMS
Notice of Upcoming Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	Yes	Any time during the 6th month, or no later than 7 business days after the 6th month as long as the notice is sent before the disenrollment transaction is submitted to CMS
Final Confirmation of Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	No	NA
Disenrollment Due to Death (Exh. 13)	50.2.3, 50.4.2, 60.3.1	No	NA
Disenrollment Due to Loss of Part A and/or Part B Coverage (Exh. 14)	50.2.2, 50.4.2, 60.3.1	No	NA
Notices on Terminations/Nonrenewals	50.2.4	Yes	Follow requirements in 42 CFR 422.506 - 422.512
Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	50.3.2	Yes	NA
Disenrollment for Disruptive Behavior (no exhibit)	50.3.2	Yes	Before the disenrollment transaction is submitted to CMS
Disenrollment for Fraud and Abuse (no exhibit)	50.3.3	Yes	Before the disenrollment transaction is submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	60.3, 60.3.1	Yes	7 business days of initial contact with member

Notice	Section	Required?	Timeframe
Offering Beneficiary Services, Pending Correction of Erroneous Part A/B Termination (Exh. 16)	60.3, 60.3.1	Yes	7 business days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another M+C organization (Exh. 17)	60.3, 60.3.2	Yes	7 business days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	60.3.2	Yes	7 business days after information was due to M+C organization
Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)	50.3.1	Yes	Within 20 days after delinquent premiums due
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	50.3.1	Yes	Before the disenrollment transaction is submitted to CMS
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	50.3.1	No	NA
Failure to Pay Plan Premiums - Notice of Reduction in Coverage (Exh. 22)	50.3.1	Yes	Prior to effective date of reduction in coverage
Public Notices For Closing Enrollment (Exh. 23)	40.5	Yes	30 calendar days before closure (15 days if related to CMS approved capacity limit)
Notice that Election Placed on Waiting List (no exhibit)	40.5.1, 40.5.2	Yes	7 business days of receiving enrollment form or of approval from CMS to limit enrollment
Re-affirming Intent to Not Enroll (no exhibit)	40.5.1, 40.5.2	No	NA
Intent to Not Process Enrollment (no exhibit)	40.5.1, 40.5.2	Yes	7 business days of learning beneficiary no longer wants to enroll
Medigap Rights per Special Election Period (Exh. 24)	50.2, 50.1	No	Upon request.

Notice	Section	Required?	Timeframe
Request to cancel enrollment (Exh. 25)	60.2.1	Yes	7 business days of request
Request to cancel disenrollment (Exh. 26)	60.2.2	Yes	7 business days of request

Appendix 2: Data Elements Required to Complete the Enrollment *Election* (2 Pages)

(Rev. 26, 07-25-03)

Referenced in section(s): 20, 20.4, 40.2, *40.4.1*

All data elements with a "Yes" in the "Required before enrollment complete" column are necessary in order for the enrollment to be considered complete.

	Data Element	Required before enrollment complete?	Exhibit # in which data element appears
1	M+C Plan name	Yes	1, 2, 3, 3a
2	Effective date of coverage	No[1]	1, 2, 3, 3a
3	Beneficiary name	Yes	1, 2, 3, 3a
4	Beneficiary Medicare number	Yes	1, 2, 3
5	Beneficiary Date of Birth	Yes	1, 2
6	Beneficiary Sex	Yes	1, 2
7	Permanent Residence Address	Yes	1, 2, 3
8	Mailing Address	No	1, 2, 3
9	Beneficiary Telephone Number	No	1, 2, 3
10	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No	1, 2
11	Language preferences (Optional Field)	No	1, 2

[1] While it is true the effective date must be established in order to complete the election, it is not the beneficiary who fills out this data element. As indicated in section 40.2, the effective date of coverage is filled in by the M+C organization. Therefore, the "no" in this column is simply intended to mean that the beneficiary does not have to fill in this data element in order to complete the election.

	Data Element	Required before enrollment complete?	Exhibit # in which data element appears
12	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	2
13	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No	2
14	Medicare information contained on sample Medicare card, or copy of card	No[2]	1, 2
15	M+C Plan/Product choice	Yes	1, 2, 3a
16	M+C Product/Premium Choice	Yes	3
17	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	2
18	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No	1, 2, 3
19	Beneficiary signature and/or Beneficiary Representative Signature	Yes*3*	1, 2, 3,3a
20	Signature and Relationship of any individual who helped beneficiary fill out form (if applicable)	Yes*4*	1, 2, 3, 3a
21	Date of signatures	No[5]	1, 2, 3, 3a

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[2] As stated in §40.2, an M+C organization may not refuse to accept an enrollment form when an individual does not have his/her Medicare card available at the time s/he fills out an enrollment form; however, the enrollment form will not be considered complete until the M+C organization has obtained evidence of entitlement to Medicare Part A and enrollment in Part B. We recognize that the M+C organization needs, at a minimum, the Medicare number in order to verify entitlement to Part A and enrollment in Part B; we have accounted for the need for this data element under data element number 4.

3 For Employer Group M+C enrollment elections as described in §40.4.1, a signature is not required.

4 Same as footnote number 3.

	Data Element	Required before enrollment complete?	Exhibit # in which data element appears
22	Response to question 1 on page 3 ("Please read and answer these questions")	Yes	1, 2
23	Response to questions 2 - 5 on page 3 ("Please read and answer these questions")	No	1, 2
24	Initials/annotation next to all statements on page 4 ("Please read these sentences and put your initials next to them")	M+CO decision[6]	1, 2
25	Employer Name and Group Number	Yes	2
26	Question of which M+C plan/premium the beneficiary is currently a member of and to which M+C plan/premium the beneficiary is changing	Yes	3

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[5] As explained in §40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the M+C organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element. *For employer group M+C elections as described in §40.4.1, the "signature date" is the date the employer's process was completed as recorded.*

[6] As explained in §40.2, the M+C organization should decide whether it will require the beneficiary=s initials on this section of the form or consider the beneficiary signature to be adequate. If initials are required, the beneficiary must complete Item #24. If the M+C organization uses the signature and not initials, the beneficiary need not complete Item #24.

Appendix 3: Timeframes for Required Enrollment & Disenrollment Monitoring Elements

To be added in a future update.

Exhibit 1: Model Individual Enrollment Form ("Election" may also be used) (4 Pages)

(Rev. 26, 07-25-03)

Referenced in section(s): 10, 40.1, 40.2, 50.1

Medicare +Choice Plan Name: _____

Your Name:_____**Your Medicare Number:** _____

Date of Birth (month/day/year): _____ **Male** _____**Female** _____

Permanent Residence Address:

_____	_____	_____	____	_____
Number, Street, Apartment #	City	County	State	Zip Code

Telephone Number: _____ _____

Area Code Number

Mailing Address (if different from permanent address)

_____	_____	_____	____	_____
Number, Street, Apartment #	City	County	State	Zip Code

Name of person to contact in case of emergency [Optional field] _____

Phone Number: [Optional field]_____**Relationship to You** [Optional field]_____

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

___ Language A (e.g., Chinese)

___ Language B (e.g., Spanish)

Medicare Health Insurance

Social Security Act

Name of Beneficiary:

Medicare Claim Number _____ Sex ___

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

__ Hospital Insurance (Part A)_____

__ Medical Insurance (Part B)_____

- *Medicare Information: Fill in these blanks so they match your Medicare card, or*
- *Attach a copy of your Medicare card or your Letter from the Social Security Administration or Railroad Board.*

We cannot call this enrollment form "finished" until you have given us this information.

Your Medicare +Choice plan choice:

Please check which product you want to enroll in: [Optional field for plans with more than 1 product]

___	Product ABC	[optional] Premium = $XX per month
___	Product XYZ	[optional] Premium = $XX per month

Name of chosen Primary Care Physician (PCP), clinic or health center (if required):

[This field is not necessary for PPOs]

Release of Information: By joining this plan, I allow the Centers for Medicare & Medicaid Services *(CMS)* to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date my Medicare +Choice plan coverage begins, I must get all of my health care from the Medicare +Choice plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the Medicare +Choice organization and other services contained in my Medicare +Choice plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE MEDICARE + CHOICE PLAN WILL PAY FOR THE SERVICES. [Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers]

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this Medicare +Choice plan.

Your Signature* _____ Date: _____

*If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law; or another person who is authorized by State law, must sign the following line. **Attach a copy of proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature _____ Date: _____

*If anyone helped *you* fill out this form, s/he must sign the following line:

Signature _____ Date: _____ Relationship:_____

Please read and answer these questions:

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.

   Yes _____ No _____

Note: If you have ESRD, you cannot enroll in this plan unless you are already enrolled in the Medicare + Choice organization as a commercial member or you were affected by the non-renewal of another Medicare + Choice plan after December 31, 1998. If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Have you recently moved into this plan's service area?

   Yes _____ No _____

Your answer to the following questions will <u>not</u> keep you from enrolling in this plan.

4. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?

   Yes _____ No _____

   If yes, Name of Institution _____

   Address of Institution (number and street) _____

   Phone Number of Institution _____

   Your Date of Admission into Institution _____

5. Do you receive Medicaid benefits?

   Yes_____ (If yes, Medicaid Number: _____) No _____

6. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?

   Yes _____ No _____

   If yes, what kind of insurance do you have? _____

   What is the name of your insurance? _____

7. Do you or your spouse work?

   Yes _____ No _____

Please read these sentences and put your initials next to them:

1. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using the plan's services, the plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan, or Medigap *or* Medicare Select plan** until I get that approval from the plan. _____ (Initials)

2. I understand that I must keep my **Medicare Part A and Part B insurance** by paying the Part B premiums and the Part A premiums, if applicable. _____ (Initials)

3. I understand that I can be a member of only **one Medicare + Choice plan at a time**. By enrolling in this plan, I will automatically be disenrolled from any other Medicare + Choice plan of which I am currently a member. _____ (Initials)

4. I understand that since I can be a member of only one Medicare +Choice plan at a time, I **cannot enroll in more than one Medicare + Choice plan** with the same effective date of coverage. If I do this, my enrollments may be canceled and I will have to fill out a new enrollment form to become a member of a Medicare + Choice plan. _____(Initials)

5. I understand that I may **disenroll** from this plan by sending a written request to the plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE(1-800-633-4227). TTY users should call 1-877-486-2048. Until the effective date of disenrollment, I must keep getting health care from the plan doctors. _____ (Initials)

6. I understand that as a member of the plan, I have the right to **ask about the plan's decision** about payment or services if I disagree. _____ (Initials)

7. I understand that it is my job to tell the plan before I **move** out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me. _____ (Initials)

Office Use Only:
Plan ID #:_____
Effective Date of Coverage: _____
ICEP: _____ OEP: _____ AEP: _____ SEP (type): _____

Exhibit 2: Model Employer Group Health Plan Enrollment (the term "Election" may also be used) Form (5 Pages)

(Rev. 26, 07-25-03)

Referenced in section(s): 10, 20.4, 40, 40.1

***Medicare + Choice* Plan Name**: _____

Effective Date (to be filled in by the plan): _____

Employer Name: _____ Group Number: _____

Your Name:_____Your Medicare Number: _____

Date of Birth (month/day/year): _____ Male _____Female _____

Permanent Residence Address:

_____ _____ _____ ____ _____

Number, Street, Apartment # City County State Zip Code

Telephone Number: _____ _____

Area Code Number

Mailing Address (if different from permanent address)

_____ _____ _____ ____ _____

Number, Street, Apartment # City County State Zip Code

Name of person to contact in case of emergency [Optional field] _____

Phone Number: [Optional field]_____**Relationship to Individual** [Optional field]_____

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

___ Language A (e.g., Chinese) ___ Language B (e.g., Spanish)

Are you the retiree? _____ Yes _____ No

If yes, retirement date (month/date/year) _____

If no, name of retiree _____

Are you covering a spouse or dependents under this Employer Plan? ___ Yes ____ No

If yes, name of spouse _____ Name of dependent(s) _____

Medicare Information:

- *F*ill in these blanks so they *match* your Medicare card*, or*
- *A*ttach a copy of your Medicare card or your Letter from the Social Security Administration or Railroad Retirement Board.

We cannot call this enrollment form "finished" until you have given us this information.

Medicare Health Insurance

Social Security Act

Name of Beneficiary:_____

Medicare Claim Number Sex

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To Effective Date

Hospital Insurance (Part A)_____

Medical Insurance (Part B)_____

Your *Medicare +Choice* plan choice: _____

Are you currently a member of the Health Plan selected? _____Yes _____No

If yes, Plan Member Identification Number_____

Please check which product you want to enroll in: [Optional field for plans with *more than* 1 product]

___ Product ABC [optional] Premium = $XX per month

___ Product XYZ [optional] Premium = $XX per month

Name of chosen Primary Care Physician (PCP), clinic or health center (if required):

[This field is not necessary for PPOs] _____

Release of Information: By joining this plan, I allow the Centers for Medicare & Medicaid Services *(CMS)* to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

<u>Lock-In:</u> I understand that, beginning on the date my *Medicare +Choice* plan coverage begins, I must get all of my health care from the *Medicare +Choice* plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the *Medicare +Choice* organization and other services contained in my Medicare +Choice plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE *MEDICARE + CHOICE* PLAN WILL PAY FOR THE SERVICES. (Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers.)

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this *Medicare +Choice* plan

Your Signature* _____ Date: _____

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, must sign the following line. **Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature _____ Date: _____

*If anyone helped the individual fill out this form (with the exception of the effective date), s/he must sign the following line:

Signature _____Date: _____ Relationship to Individual _____

Please read and answer these questions:

1. Do you have End Stage Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive.

   Yes_____ No_____

   Note: If you have ESRD, you can not enroll in this plan unless you are already enrolled in the *Medicare + Choice* Organization as a commercial member or you were affected by the non-renewal of another *Medicare + Choice* plan after December 31, 1998.If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.

Your answers to the following questions will <u>not</u> keep you from enrolling in this plan.

2. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?

   Yes_____ No_____

   If yes, Name of Institution _____

   Address of Institution (number and street _____

   Phone Number of Institution _____

   Your Date of Admission into Institution _____

3. Do you receive Medicaid benefits?

   Yes_____ No_____

   If yes, Medicaid Number: _____

4. Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, Workers' Compensation, or VA benefits?

   Yes_____ No_____

   If yes, what kind of insurance do you have? _____

   What is the name of your insurance? _____

5. Do you or your spouse work?

   Yes_____ No_____

Please read these sentences and put your initials next to them:

1. I understand that while the "effective date of coverage" on the first page of this form is when I should begin using the plan's services, the plan will still send me final approval of my enrollment in the plan. I understand that I should not disenroll from **any Medicare supplement plan or Medigap *or M*edicare Select plan** until I get that approval from the plan. _____ (Initials)

2. I understand that I must keep my **Medicare Part A and Part B insurance** by continuing to pay the Part B premiums and the Part A premiums, if applicable. _____ (Initials)

3. I understand that I can be a member of only **one *Medicare +Choice* plan at a time**. By enrolling in this plan, I will automatically be disenrolled from any other *Medicare + Choice* plan of which I am currently a member. _____ (Initials)

4. I understand that since I can be a member of only one Medicare +Choice plan at a time, I **cannot enroll in more than one Medicare +Choice plan** with the same effective date of coverage. If I do this, my enrollments may be canceled and I will have to fill out a new enrollment form to become a member of a Medicare + Choice plan. _____ (Initials)

5. I understand that I may **disenroll** from this plan by sending a written request to the employer benefits office, the plan, the Social Security Office, the Railroad Retirement Board, or by calling 1-800-MEDICARE *(1-800-633-4227). TTY users should call 1-877-486-2048.* Until the effective date of disenrollment, I must keep getting health care the Medicare managed care plan. _____ (Initials)

6. I understand that as a member of the plan, I have the right to **ask about the plan's decision** about payment or services if I disagree. _____ (Initials)

7. I understand that it is my job to tell the plan before I **move** out of the service and/or continuation area. I understand that if I move permanently out of the service and continuation area, Medicare requires the plan to disenroll me. _____ (Initials)

8. I understand that if I disenroll from this employer-sponsored plan, I will be automatically transferred to the Original Medicare Plan (fee-for-service program). Also, I understand that if I choose to enroll in a different Medicare managed care plan (whether or not it is sponsored by my employer), I will be automatically disenrolled from this employer-sponsored plan. _____ (Initials).

Exhibit 3: Model Short Enrollment Form ("Election" may also be used) (2 Pages)

(Rev. 26, 07-25-03)

This form may be used in place of the model individual enrollment form when a member of a M+C plan is enrolling into another M+C plan in the same M+CO

Referenced in section(s): 10, 20.4, 40, 40.1

If you are changing plans within {M+CO name} you should use this form. This form may not be used to enroll in {M+CO name} for the first time.

Name of Plan You are Enrolling In: _____

Name: _____ **Medicare Number:**_____

(Note: may use "member number" instead of "Medicare number")

Permanent Address:

_____ _____ _____ ____ _____

Number, Street, Apartment # City County State Zip Code

Telephone Number: _____

Area Code Number

Mailing Address (if different from permanent address)

_____ _____ _____ ____ _____

Number, Street, Apartment # City County State Zip Code

Please fill out the following:

I am currently a member of the _____ plan in _____{M+CO name} with a monthly premium of $_____ .

I would like to change to the _____ plan in _____ {M+CO name}. I understand that this plan has different health benefits and a monthly premium of $ _____ .

Have you recently **moved** into this plan's service area? Yes_____ No_____

Optional field, if M+CO will require the member to name a new PCP:

Name of chosen Primary Care Physician (PCP), clinic or health center (if required):

_____

Release of Information: By joining this plan, I allow the Centers for Medicare & Medicaid Services *(CMS)* to give information to the plan. The information will say whether I have Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B). I also allow the plan's doctors and clinics or anyone else with medical or other relevant information about me to give CMS or CMS's agents the information needed to run the Medicare program.

Lock-In: I understand that, beginning on the date my *Medicare + Choice* plan coverage begins, I must get all of my health care from my new *Medicare + Choice* plan, with the exception of emergency or urgently needed services or out-of-area dialysis services. In addition to being covered in the United States, emergency and urgently needed services are covered in certain hospitals in Mexico and Canada. I understand that services authorized by the *Medicare + Choice* plan and other services contained in my *Medicare + Choice* plan Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. I also understand that without authorization, NEITHER MEDICARE NOR THE *MEDICARE + CHOICE* PLAN WILL PAY FOR THE SERVICES. (Note: POS and PPO plans need to add a statement regarding financial liability when using non-contracted providers]

I understand that my signature on this application means that I have read and understand the contents of this application. Please read your Evidence of Coverage document to know what rules you must follow in order to receive coverage with this *Medicare +Choice* plan.

Enrollee's Signature*_____ Date: _____

*If the individual is unable to sign, a court-appointed Legal Guardian or person with Durable Power of Attorney for Health Care (DPAHC), if authorized by state law, must sign the following line. **Attach a copy of the proof of Legal Guardian, DPAHC, or proof of authorization by state law**

Signature _____ Date: _____

*If anyone helped the beneficiary fill out this form, s/he must sign the following line:

Signature _____ Date: _____ Relationship to Beneficiary: _____

Office Use Only:
Plan ID #: _____
Effective Date of Coverage: _____
ICEP: _____ OEP: _____ AEP: _____ SEP (type): _____

Exhibit 3a: Model Selection Form - *S*witch *F*rom *P*lan to *P*lan *W*ithin M+C *Organization*

(Rev. 26, 07-25-03)

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

Dear <plan name> Member:

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

If you wish to make a change in the *Medicare + Choice* plan you have with <name of M+CO> fill out the enclosed plan benefit selection form to make your choice. Remember to 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>.

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* <insert premium> and you may continue to see any <current plan> primary care doctors and specialists.

*Complete t*he 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 our Member Services Department 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 Benefit Selection Form

Date:

Member Name:

Member Number:

I wish to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, it generally will be effective the 1st of the following month.

Please check the appropriate box below <list all available plans>:

____ <Name of Plan>

<cost of premium>

<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.)

____ <Name of Plan>

<cost of premium>

<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.)

Signature:_____ Date:_____

Please mail this form to:

<Insert mailing address>

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment *Election*

(Rev. 26, 07-25-03)

Referenced in section(s): 40.4.1, 60.4

Dear <Name of Member>:

Thank you for *enrolling* in <Plan name>. Starting <effective date>, you must see your <Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care. **Optional language:** This letter *is proof of* insurance *that* you should show *during* your doctor' appointments *until you get your member card from us.*

*T*he Centers for Medicare & Medicaid Services (CMS), the federal agency that runs the Medicare program, *must review all enrollments*. We will send your enrollment to CMS, and they will do a final review. When CMS finishes its review, we will send you a letter to confirm your enrollment with <Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors *on* <effective date>. Also, *do not* cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the *confirmation* letter.

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you do not have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <Plan> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <Plan>, and we may have to send you a bill for any health care you received.

Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services,** if you get health care from a non-<Plan> doctor without prior authorization, you will have to pay for the health care yourself.

** Insert information instructing member in simple terms on how to select a primary care provider/site (PCP); how to obtain *Medicare + Choice* Plan services, e.g., provide the name, phone number, and location of the PCP, include the membership identification card when possible, explain unique POS and/or PPO procedures (when applicable), explain which services do not need PCP approval (when applicable), etc. **

If you have any questions, please call our Member Services Department at <phone number>. *TTY users should call* <*TTY* number>. We are open {insert days/hours of operation and, if different, *TTY* hours of operation}. Thank you.

Exhibit 4a: Model Notice to Acknowledge Receipt of Completed Enrollment Election – Enrollment in another Plan Within the Same M+C Organization

(Rev. 26, 07-25-03)

Referenced in section(s): 40.4.1, 60.4

Dear <Name of Member>:

Thank you for your request to change your enrollment from <old Plan name> to <new Plan name>. Starting <effective date>, you must see your <new Plan> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, ***or out-of-area dialysis services****, must be given or arranged by a <Plan> doctor(s). You will need to pay our copayments when you get health care.* ***Optional language:*** *This letter is proof of insurance that you should show during your doctor's appointments****.***

The Centers for Medicare & Medicaid Services (CMS), the federal agency that runs the Medicare program, must review all enrollments. We will send your enrollment to CMS, and they will do a final review. When CMS finishes its review, we will send you a letter to confirm your enrollment with <new Plan>. But, you should not wait to get this letter before you begin using <Plan> doctors on <effective date>.

Please remember that, except for emergency or out-of-area urgent care, ***or out-of-area dialysis services,*** *if you get health care from a non-<new Plan> doctor without prior authorization, you will have to pay for the health care yourself.*

If you have any questions, please call our Member Services Department at <phone number>. TTY users should call <TTY number>. We are open {insert days/hours of operation and, if different, TTY hours of operation}. Thank you.

Exhibit 5: Model Notice to Request Information

(Rev. 26, 07-25-03)

Referenced in section(s): 40.2.2

Dear <Name of *Member*>:

Thank you for *applying with* <M+C Plan>. We cannot process your *application* until we get the following things from you:

_____ Proof of Medicare Part A and B coverage. You can send us a copy of your Medicare card or a letter from Social Security or the Railroad Retirement Board as *proof* of your Medicare coverage.

_____ A copy of your legal papers authorizing another person to act on your behalf.

_____ Other: _____

You will need to send this information to <M+C Plan name and address> by <date - 30 days from date letter provided to the beneficiary>. If you cannot send this information by <date listed above>, we will have to deny your request to enroll in our plan.

If you have any questions, please call our Member Services Department at <phone number>. *TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 6: Model Notice to Confirm Enrollment

(Rev. 26, 07-25-03)

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

*T*he Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <M+C Plan>, beginning <effective date>.

*N*ow that *we have confirmed* your enrollment, you may cancel any Medigap or supplemental insurance that you have. (Please note that if this is the first time that you are a member of a Medicare + Choice plan, you may have a trial period during which you have certain rights to *leave (*disenroll from*)* <M+C Plan> and purchase a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) for further information. *TTY users should call 1-877-486-2048.*

Please call our Member Services at <phone number> *if you have any questions. TTY users should call* <*TTY* number>.We are open <days and hours of operation>.

Exhibit 6a: Model Notice to Confirm Enrollment - *P*lan to *P*lan *W*ithin M+C O*rganization*

(Rev. 26, 07-25-03)

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

*T*he Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <M+C Plan>, beginning <effective date>.

Please call our Member Services at <phone number> *if you have any questions. TTY users should call* <*TTY* number>. We are open <days and hours of operation>.

Exhibit 7: Model Notice for M+C *Organization Denial of Enrollment*

(Rev. 26, 07-25-03)

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

Thank you for applying *with* <M+C Plan>. We cannot accept your *request* for enrollment in <M+C Plan> because:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease (ESRD)

4. _____ Your permanent residence is outside our service or continuation area

5. _____ We did not receive the information we requested from you within 30 days of our request.

Medicare MSA plans add #6:

6. _____ National enrollment in Medicare Medical Savings Accounts has reached the maximum amount allowed under law

If we checked item 1 or 2, and it is correct, then we will send you a bill for any services you received. If we checked anything else and it is correct, then we may send you a bill for any services you received.

If *the item(s)* we checked <is> *<are>* wrong, or if you have any questions, please call us at <phone number>. *TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 8: Model Notice for CMS Rejection of Enrollment

(Rev. 26, 07-25-03)

Referenced in section(s): 40.4.2

Dear <Name of Beneficiary>:

*T*he Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <M+C Plan> due to the reason(s) checked below:

1. _____ You do not have Medicare Part A

2. _____ You do not have Medicare Part B

3. _____ You have End Stage Renal Disease (ESRD)

4. _____ You signed a form to enroll in a different plan for the same effective date, which canceled your application with <M+C Plan>. This may mean that you are still enrolled in the Original Medicare Plan or in the Medicare + Choice plan that you were enrolled in before you applied for membership in our plan.

If *we correctly* checked number 1 or 2, then we will send you a bill for any services you received from us.

If we *correctly* checked number 3 or 4, then we may send you a bill for any services you received from us.

If *the item(s)* we checked <is> *<are> wrong*, or if you have any questions, please call us at <phone number>.*TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 9: Model Notice to Send Out Disenrollment Form

(Rev. 26, 07-25-03)

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you asked for. Please *choose one of the following steps to disenroll:*

1. *F*ill out the whole form, sign it, and send it back to us in the enclosed envelope. You can also fax the form *with a readable* signature and date *to us at* <fax number>.

2. *V*isiting your local Social Security Office or Railroad Retirement Board Office.

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

You must keep using <M+C Plan> doctors until your disenrollment date. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <M+C plan>'s network. We will mail a copy of the disenrollment form back to you with the date of your disenrollment written on the form.

IMPORTANT NOTE ABOUT *MEDIGAP* RIGHTS

If you *will be changing* to *the* Original Medicare Plan you might have a *special temporary* right to buy a *Medigap policy, also known as* Medicare supplement insurance, even if you have health problems. *You do not have to buy Medigap insurance to get coverage under the Original Medicare Plan.*

You may have a special temporary right to buy a Medigap policy if any of the following apply to you:

- ***Medigap Open Enrollment*** *- If you are age 65 or older and you enrolled in Medicare Part B within the past 6 months.*

- **Moving -** If you move out of <M+C Plan>'s service area *you need to apply for a Medigap policy no later than 63 days after the date your coverage in our plan ends.*

- ***Loss of*** **Medicaid** - If you *have been* receiving *any form of medical assistance (Medicaid)* from the State *(for example, if Medicaid was paying your* Medicare premiums*, deductibles or coinsurance) and you recently lost your Medicaid coverage, you can choose to disenroll from our plan and change to the Original Medicare Plan. If you change to the Original Medicare Plan and you would like to buy a Medigap policy, you should apply for a Medigap policy no later than 63 days after your coverage in our plan ends.*

- ***Trial Period*** *– You can "try out" a Medicare + Choice Plan for 12 months and keep certain Medigap rights. This is sometimes called a "trial period." You might be in a trial period if any of the following happened within the last 12 (in some cases 24) months:*

  You dropped a Medigap policy to join this plan, and this is the first time you have been in a Medicare + Choice Plan; or

  You enrolled in this plan when you were first eligible for Medicare at age 65; or,

  You lost coverage under another Medicare + Choice Plan while you were still in your 12-month trial period and you immediately enrolled in our Medicare + Choice Plan.

  To take advantage of these rights, you must voluntarily disenroll from our plan before your trial period ends and you must apply for a Medigap policy no later than 63 days after your coverage in our plan ends.

- *You may also have Medigap rights in o*ther special circumstances defined by Medicare.

Federal law requires the protections described above. ***Your State may have laws that provide more*** **Medigap protections.** *If you have questions, you should c*ontact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap *policies* in your State. *Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048.*

Your enrollment in a Medigap policy is not automatic. You must contact an insurance company that sells Medigap *policies* and request an application.

If you need any help, please call us at <phone number>. *TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>.

Thank you.

Attachment

Exhibit 10: Model Disenrollment Form

(Rev. 26, 07-25-03)

Referenced in section(s): 10

If you have already joined or intend to join a new Medicare managed care plan or other Medicare + Choice Plan (like a PPO, Private Fee-for-Service Plan, etc.), you do not have to complete this form.

DATE_____

(Please Print in Ink)

Member's Name _____

First Middle Last

Address_____

City State Zip County

Telephone _____

Male _____ Female_____ Date of Birth_____

Medicare #_____

Please carefully read and complete the following information before signing and dating this disenrollment form:

On the effective date of enrollment in another Medicare managed care *or other Medicare + Choice Plan Medicare will* automatically cancel *your current membership in <M+C plan name>.*

If you request disenrollment*, you* must continue to receive all medical care from <M+C plan name> until the effective date of disenrollment. *C*ontact us to verify your disenrollment before you seek medical services outside of <M+C plan>'s network. We will notify you of your effective date after we have received this form from you.

Requested disenrollment date:_____

_____ _____

Beneficiary Signature Date

OR

_____ _____

Beneficiary Guardian Signature Date

Exhibit 11: Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

(Rev. 26, 07-25-03)

Referenced in section(s): 50.1, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <M+C Plan>. *Y*ou will be disenrolled starting <effective date.> Beginning <effective date>, <M+C Plan> will not cover any health care you receive.

Until <effective date>, you must keep using <M+C Plan> doctors, except for emergencies and urgently needed care and out-of-area dialysis services. Beginning <effective date>, you can see any doctor through the Original Medicare Plan, unless you have enrolled in another *Medicare + Choice* plan.

Please be patient. It will take a few weeks for us to process your disenrollment and update Medicare's records. *If* your doctors need to send Medicare claims, you *may want to tell them that you* just disenrolled from <M+C Plan> and there may be a short delay in *updating* your records .

IMPORTANT NOTE ABOUT MEDIGAP RIGHTS

If you *will be changing to the* Original Medicare *Plan* you might have a *special temporary* right to buy *a Medigap policy, also known as* Medicare supplement insurance, even if you have health problems. *You do not have to buy Medigap insurance to get coverage under the Original Medicare Plan.*

You may have a special temporary right to buy a Medigap policy if any of the following apply to you:

- ***Medigap Open Enrollment* –** *If you are age 65 or older and you enrolled in Medicare Part B within the past 6 months.*
- **Moving -** If you move out of <M+C Plan>'s service area *you need to apply for a Medigap policy no later than 63 days after the date your coverage in our plan ends.*
- ***Loss of* Medicaid -** If you *have been* receiving *any form of medical assistance (Medicaid)* from the State *(for example, if Medicaid was paying your Medicare premiums, deductibles or co-insurance) and you recently lost your Medicaid coverage, you can choose to disenroll from our plan and change to the Original Medicare Plan. If you change to the Original Medicare Plan and you would like to buy a Medigap policy, you should apply for a Medigap policy no later than 63 days after your coverage in our plan ends.*

- ***Trial Period*** **-** *You can "try out" a Medicare + Choice Plan for 12 months and keep certain Medigap rights. This is sometimes called a "trial period." You might be in a trial period if any of the following happened within the last 12 (in some cases 24) months:*

  You dropped a Medigap policy to join this plan, and this is the first time you have been in a Medicare + Choice Plan; or

  You enrolled in this plan when you were first eligible for Medicare at age 65; or,

  You lost coverage under another Medicare + Choice Plan while you were still in your 12-month trial period and you immediately enrolled in our Medicare + Choice Plan

  To take advantage of these rights, you must voluntarily disenroll from our plan before your trial period ends and you must apply for a Medigap policy no later than 63 days after your coverage in our plan ends.

- *You may also have Medigap rights in o*ther special circumstances defined by Medicare.

Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** *If you have questions, you should c*ontact your State Health Insurance Program <insert name of SHIP > at <SHIP phone number> to get more information about Medigap *policies* in your State. *Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048.*

Your enrollment in a Medigap policy is not automatic. You must contact an insurance company that sells Medigap *policies* and request an application.

If you need any help, please call us at <phone number>. TTY users should call <*TTY* number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 12: Model Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing

(Rev. 26, 07-25-03)

Referenced in section(s): 50.1, 50.4.1, 60.3.2

Dear <Name of Beneficiary>:

This is to confirm your disenrollment from <M+C Plan>. *Beginning* <effective date,> <M+C Plan> will not cover any health care you receive. *If* your doctor need*s* to send Medicare claims, *you may want to tell them that there may be a short delay in updating* you*r records since you* just disenrolled from <M+C Plan>.

IMPORTANT NOTE ABOUT MEDIGAP RIGHTS

If you *will be changing to the* Original Medicare *Plan* you might have a *special temporary* right to buy a *Medigap policy, also known as* Medicare supplement insurance, even if you have health problems. *You do not have to buy Medigap insurance to get coverage under the Original Medicare Plan.*

You may have a special temporary right to buy a Medigap policy if any of the following apply to you:

- ***Medigap Open Enrollment.*** *- If you are age 65 or older and you enrolled in Medicare Part B within the past 6 months*

- **Moving** - If you move out of <M+C Plan>'s service area *you need to apply for a Medigap policy no later than 63 days after the date your coverage in our plan ends.*

- ***Loss of*** **Medicaid** - If you *have been* receiving *any form of medical assistance (Medicaid)* from the State *(for example, if Medicaid was paying your Medicare premiums, deductibles or co-insurance) and you recently lost your Medicaid coverage, you can choose to disenroll from our plan and change to the Original Medicare Plan. If you change to the Original Medicare Plan and you would like to buy a Medigap policy, you should apply for a Medigap policy no later than 63 days after your coverage in our plan ends*.

- ***Trial Period*** *- You can "try out" a Medicare + Choice Plan for 12 months and keep certain Medigap rights. This is sometimes called a "trial period." You might be in a trial period if any of the following happened within the last 12 (in some cases24) months:*

  You dropped a Medigap policy to join this plan, and this is the first time you have been in a Medicare + Choice Plan; or

You enrolled in this plan when you were first eligible for Medicare at age 65; or,

You lost coverage under another Medicare + Choice plan while you were still in your 12-month trial period and you immediately enrolled in our Medicare + Choice Plan.

To take advantage of these rights, you must voluntarily disenroll from our plan before your trial period ends and you must apply for a Medigap policy no later than 63 days after your coverage in our plan ends..

- *You may also have Medigap rights in o*ther special circumstances defined by Medicare.

Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** *If you have questions you should c*ontact your State Health Insurance Program <insert name of SHIP > at <insert SHIP phone number> to get more *information about Medigap policies* in your State*. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048.*

Your enrollment in a Medigap policy is not automatic. You must contact an insurance company that sells Medigap *policies* and request an application.

If you think you did not disenroll from <M+C Plan>, and you want to keep being a member of our plan, please call us right away at <phone number> or, for the hearing impaired, at <*TTY* number> so we can make sure you stay a member of our plan. We are open <insert days and hours of operation>. Thank you.

Exhibit 13: Model Notice of Disenrollment Due to Death

(Rev. 26, 07-25-03)

Referenced in section(s): 50.2.3, 50.4.2, 60.3.1

Note: Address letter "To The Estate of <Member's Name>" or "To <Member's Name>

To The Estate of <Member's Name> (or To <Member's Name>):

The Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, has told us of the death of <Member's Name>. Please accept our condolences.

<Member's name>'s coverage in <M+C Plan> has ended as of <effective date>. If membership premiums were paid for any month after <effective date>, we will refund the Estate within 30 days of this letter.

If this information is wrong, please call us at <phone number>. *TTY users should call <TTY* number>. We are open <insert days and hours of operation>.

Exhibit 14: Model Notice of Disenrollment Due to Loss of Medicare Part A and/or Part B

(Rev. 26, 07-25-03)

Referenced in section(s): 50.2.2, 50.4.2, 60.3.1

Dear <Name of Member>:

*T*he Centers for Medicare & Medicaid Services (CMS) has told us that you no longer have Medicare Part <insert A and/or B, as appropriate (cost plans may only insert "B")> insurance. Therefore, your membership in <M+C Plan> was ended beginning <date>. If this information is wrong, and you want to *stay* a member of our plan, please contact us. Also, if you have not already done so, please contact your local Social Security office to have their records corrected.

If you have any questions, please call us at <phone number>. *TTY users should call <TTY* number>. We are open <insert days and hours of operation>. Thank you.

Exhibit 15: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

(Rev. 26, 07-25-03)

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

The Centers for Medicare & Medicaid Services' *(CMS)* records *incorrectly* show you a*s* deceased.

If you have not already done so, please go to your local Social Security Office and ask them to correct your records. Please send us <M+C Plan> written proof *at <address> after you do* this. When we receive this proof, we will tell the *CMS* to correct its records.

In the meantime, you should keep using your <M+C Plan> primary care physician for your health care. **(Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate)** If you have any questions or need help, please call us at < phone number>. *TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <M + C Plan>.

Exhibit 16: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination

(Rev. 26, 07-25-03)

Referenced in section(s): 60.3, 60.3.1

Dear < Name of Member>:

On <Date of request> you told us that your enrollment in Medicare was ended in error and that you wanted to *stay* a member of <M+C Plan>. *To do this, please complete the following steps:*

1. *C*ontact the Social Security Administration (SSA) to have them fix their records.

2. *Ask* SSA give you a letter that says the*y have fixed your* records.

3. *S*end the letter from SSA to us at: <address of M+C Plan> *in the enclosed* postage-paid envelope. When we receive this *letter*, we will tell the Centers for Medicare & Medicaid Services *(CMS)* to correct its records.

In the meantime, you should keep using your <M+C Plan> primary care physician for your health care. (**Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate.)** *If* we find out that you do not have Medicare Part <insert "A" and/or "B" as appropriate>, you will have to pay for any service you received after the disenrollment date.

If you have any questions or need help, please call us at <phone number>. *TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>.

Thank you for your continued membership in <M+C Plan>.

Exhibit 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another M+C O*rganization*

(Rev. 26, 07-25-03)

Referenced in section(s): 60.3, 60.3.2

Dear <Name of Member>:

Thank you for letting us know you want to *stay* a member of <M+C Plan> after we sent you a letter that said we had disenrolled you from our plan.

Based on what you told us, we understand that you canceled your membership in the other plan and want to *stay* a member of <M+C Plan>. Please send us a letter *by* <insert date: 30-days from date of disenrollment *notice*>, that says you want to *stay* a member of <M+C Plan>. Your letter must also say whether or not you got services from non- <M+C Plan> doctors since <original effective date of disenrollment>. If you did not get any services from non- <M+C Plan> doctors since <original effective date of disenrollment>, we will fix our records after we receive your letter.

In the meantime, you should keep seeing your <M+C Plan> primary care physician for your health care.(**Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate. This sentence is optional for plans that do not require PCPs)**

If you have any questions or need help, please call us at <phone number>. *TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>.

Exhibit 18: Model Notice to Close Out Request for Reinstatement

(Rev. 26, 07-25-03)

Referenced in section(s): 60.3.2

Dear <Name of Beneficiary>:

We cannot process your request *to be reinstated in <M+C Plan>* because *we* have not *received your* letter asking for reinstatement. As discussed in our letter of <date of letter> you *must* send us a letter by <date placed on notice in exhibit 19>.

The <effective date> date of disenrollment remains in effect. If you have used <M+C Plan> services after this disenrollment date, we will have to bill you for any services you received.

If you have any questions, please call <phone number>. *TTY users should call <TTY* number>. We are open <insert days and hours of operation>.

Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage

(Rev. 26, 07-25-03)

Referenced in section(s): 50.3.1

Dear <Name of Member>:

Our records show that we have not received payment for your plan premium as of <Date>.

M+COs who will disenroll all members (and not use the downgrade option) use the following sentence: If we do not get payment by <90 days from date of this letter>, we will have to disenroll you from <M+C Plan>. After the disenrollment you will be covered by the Original Medicare *P*lan instead of <M+C Plan>.

Note: As required in section 50.3.1, the M+CO must state whether full payment of premiums is due to prevent disenrollment.

M+COs who will downgrade the membership for all members use the following sentences: If we do not get payment, we will make some changes to your membership in <M+C plan name> that will reduce the amount of health care coverage you have in <M+C plan name>. *T*his means that (describe lower level of benefits, e.g., prescription drugs or routing dental care will not be covered) beginning <date>.

Note: As required in section 50.3.1, the M+CO must state whether full payment of premiums is due to prevent the downgrade.

If you have been receiving any form of medical assistance (Medicaid) from the State (including paying your premiums, deductibles, or coinsurance), you should check with the State Medicaid Agency to find out if they have been paying for, or have stopped paying for, you plan premium. If you are no longer eligible for assistance from Medicaid, you may have a special temporary right to buy a Medigap policy if you voluntarily disenroll from our plan. If you have questions, you should contact your State Health Insurance Program, <name of SHIP>, at <SHIP phone number(s)> to get more information.

If you *wish to* disenroll from <M+C Plan> *and change* to *the* Original Medicare *Plan* now, you *should do one of these three things:*

1. *Send* us *a written* request *at* <M+C Plan address>.

2. Contact your local Social Security Office or Railroad Retirement Board Office.

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

You must keep using <M+C Plan name> doctors except for emergency or urgently needed care or out-of-area dialysis services until you are no longer a member.

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>.

Exhibit 20: Model Notice on Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment

(Rev. 26, 07-25-03)

Referenced in section(s): 50.3.1

Dear <Name of Member>:

On <date> we sent you a letter that said your plan premium was overdue. The letter said that if we did not get payment from you, we would disenroll you from <M+C Plan>. *S*ince we did not receive that payment, we asked the Centers for Medicare & Medicaid Services *(CMS)* to disenroll you from <M+C Plan> beginning <date>.

Due to your disenrollment from <M+C Plan>, you *<are>* covered by the Original Medicare Plan*, beginning <effective date>.*

You have the right to ask us to *reconsider* this decision through the grievance procedure written in your Member Handbook.

Please note that until <disenrollment effective date>, you must keep using <M+C Plan> doctors except for emergency or urgently needed care or out-of-area dialysis services. After that date, you can see any doctor through the Original Medicare Plan, unless you join another Medicare managed care *or Medicare + Choice P*lan.

If you think that 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>*.

Exhibit 21: Model Notice on Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment

(Rev. 26, 07-25-03)

Referenced in section(s): 50.3.1

Dear <Name of Beneficiary>:

The Centers for Medicare & Medicaid Services *(CMS)*, the federal agency that runs the Medicare program, *has confirmed* your disenrollment from <M+C Plan> due to non-payment of plan premium. Your disenrollment begins <effective date>.

Due to your disenrollment from <M+C Plan>, you are now covered by the Original Medicare plan.

You have the right to ask us to *reconsider your disenrollment* through the grievance procedure written in your Member Handbook.

If you have any questions, or need help, please call us at <phone number> *between <hours and days of operation>. TTY users should call <TTY* number>.

Exhibit 22: Model Notice on Failure to Pay Plan Premiums - Notice of Reduction in Coverage

(Rev. 26, 07-25-03)

Referenced in section(s): 50.3.1

Dear <Name of Member>:

We recently sent you a letter dated <date> that said your plan premium was overdue. The letter said that if we did not get payment from you, we would have to make some changes in your membership in <M+C Plan>. Our records show that we did not get payment from you as of <Date>. Therefore, we have reduced your coverage in <M+C Plan>, beginning <effective date>.

<Explain *in simple terms* lower level of benefits, e.g., prescription drugs or routing dental care will not be covered>

Please note that unless you disenroll from <M+C Plan>, you must keep using <M+C Plan> doctors except for emergency or urgently needed care or out-of-area dialysis services.

You have the right to ask us to reconsider this change through the grievance procedure written in your Member Handbook.

If you want to disenroll from <M+C Plan> *and return to the Original Medicare Plan now, you should do one of these three things:*

1. *S*end *us* your *written* request to <M+C Plan *or fax it to us at <fax number>*.
2. *C*ontact your local Social Security District Office or *Railroad Retirement Board Office.*
3. *C*all 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. *(*1-800-633-4227).

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>.

Exhibit 23: Model Notices For Closing Enrollment (2 pages)

(Rev. 26, 07-25-03)

Referenced in section(s): 30

Model A: Closing Enrollment for Partial Month(s)

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date] [insert name of M+C organization] will no longer offer continuous open enrollment under its *Medicare +Choice* contract with the Centers for Medicare & Medicaid Services for [insert plan name] in [insert service area].

Instead, [insert name of M+C organization] will offer open enrollment for all eligible individuals from the [insert date] to the [insert date] of each month.

[Insert name of M+C organization] will continue to accept enrollments during an entire month into [insert plan name] from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, during the Annual Election Period in November, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from all eligible individuals during the entire month.

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of M+C organization] at [insert phone number] *between [insert time frames]*. *TTY users should call* [insert *TTY* number].

Model B: Closing Enrollment for Whole Month(s)

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date] [insert name of M+C organization] will no longer offer open enrollment under its *Medicare +Choice* contract with the Centers for Medicare & Medicaid Services for [insert plan name] in [insert service area].

However, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, during the Annual Election Period in November, [insert name of M+C organization] will continue to accept enrollments into [insert plan name] from **all** eligible individuals.

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of M+C organization] at [insert phone number] between [insert time frames]. *TTY* users should call [insert *TTY* number].

Model C: Closing Enrollment for Capacity Reasons

[Insert name of M+C organization] PUBLIC NOTICE

As of [insert date], [insert name of M+C organization] will no longer accept enrollment under its *Medicare +Choice* contract with the Centers for Medicare & Medicaid Services *(CMS)* for [insert plan name] in [insert service area].

The [insert plan] has been approved for a capacity limit by *CMS.* A capacity limit allows a *Medicare +Choice* Organization to limit enrollment in a plan once a specific number of people join the plan. This is based primarily on the accessibility and availability of providers to provide services to members of the plan.

Current members of [insert name of plan] are not affected by this change. Also, individuals who are enrolled in other [insert organization name] plans may still be able to enroll in [insert name of plan] when they become eligible for Medicare.

For information regarding this notice, call [insert name of M+C organization] at [insert phone number] *between [insert time frames]. TTY users should call* [insert *TTY* number].

Exhibit 24: Model Notice for Medigap Rights Per Special Election Period

(Rev. 26, 07-25-03)

Referenced in section(s): 50.1 and 50.2

Dear <Name of Beneficiary>:

This is to confirm that you disenrolled *from <M+C Plan>* effective <insert date> *and returned to the Original Medicare Plan because of the* special circumstances *indicated below:*

_____ You permanently moved.

_____ You receive assistance from the Medicaid program.

_____ You wanted *to use* certain Medigap protections *while in* your trial period.

_____ Other circumstances defined as eligible for a Special Election Period.

Please save this letter as proof of your Medigap rights.

If you have any questions, please call us at <phone number>. *TTY users should call* <*TTY* number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 25: Acknowledgement of Request to Cancel Enrollment

(Rev. 26, 07-25-03)

Referenced in section(s): 60.2.1

Dear <*name of* member>:

As requested, we have processed your request to cancel your enrollment with <name of plan>.

Please be patient. It may take up to 45 days for Medicare to update your records. If you are in *the* Original Medicare *Plan*, you may want to tell your *doctors* that if they need to submit Medicare claims, there may be a short delay in *updating* your records.

If you were enrolled in another *Medicare + Choice* Plan before enrolling with <plan>, you may appear on their records as being disenrolled. If your intent is NOT to disenroll with that plan, you will need to notify them that you enrolled in <plan> and have cancelled your enrollment. They may request a copy of this letter for their records.

If you have any questions, please contact <plan> customer service at *<number>*, Monday through Friday between the hours of <hours>. *TTY users should call [insert TTY number]*.

Exhibit 26: Acknowledgement of Request to Cancel Disenrollment

(Rev. 26, 07-25-03)

Referenced in section(s): 60.2.2

Dear <*name of* member>:

As requested, we have processed your request to cancel your disenrollment with <insert name of plan>. You should keep using your <M+C Plan> primary care physician for your health care. (Note: plans may just say "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate) Thank you for your continued membership in the <M+C Plan>.

Please be patient. It may take up to 45 days for Medicare to update your records. You may want to tell your *doctors* that if they need to submit Medicare claims, there may be a short delay in *updating* your records.

If you have also submitted an enrollment with another *Medicare + Choice* Plan, you may appear on their records as being enrolled. If your intent is NOT to enroll with that plan and *stay* enroll*ed* in <our plan>, you will need to notify them that you are *canceling* enrollment in their plan. They may request you write them a letter for their records.

If you have any questions, please contact <plan> customer service at *<number*>, Monday through Friday between the hours of <hours>. TTY users should call [insert *TTY* number].