

# **Chapter 2**

## **Appendices**

Summary of Notice and Data Element Requirements

## Appendix 1: Summary of Notice Requirements

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

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

Notice	Section	Required?	Timeframe
Model Enrollment Form (Exh. 1)	10, 40.1, 40.2, 40.4.1	Yes <sup>1</sup>	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 6a)	40.4.2, 40.6	Yes	7 business days of reply listing
Notice to Individuals Identified on CMS Records As Members of Employer Group Receiving Subsidy (Exh. 6b)	40	Yes	7 business days of reply listing
MAO 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	50.1,	Yes	7 business days of receipt of

<sup>1</sup> Other CMS approved enrollment election mechanisms may take the place of an enrollment form

<b>Notice</b>	<b>Section</b>	<b>Required?</b>	<b>Timeframe</b>
Voluntary Disenrollment Request from Member (Exh. 11)	50.4.1		request to disenroll
Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)	50.1	No	NA
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
Denial of Disenrollment (Exh. 12a)	40.2.3	Yes	7 business days of denial determination
Rejection of Disenrollment (Exh. 12b)	50.1	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	50.3.2	Yes	Before the disenrollment

<b>Notice</b>	<b>Section</b>	<b>Required?</b>	<b>Timeframe</b>
Behavior (no exhibit)			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
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 MA 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 MA organization
Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)	50.3.1	Yes	Within 7 business days after the 1 <sup>st</sup> of the month for which 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	
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 due to Capacity Limit (Exh. 23)	40.5	Yes	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 election or of approval from CMS to limit enrollment
Re-affirming Intent to Not Enroll (no exhibit)	40.5.1, 40.5.2	No	

<b>Notice</b>	<b>Section</b>	<b>Required?</b>	<b>Timeframe</b>
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.
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
Inform Member of Auto-Enrollment (Exh. 27)	20.4.6, 40.1.6	Yes	7 business days of reply listing
Inform Member of Facilitated Enrollment (Exh. 28)	20.4.7, 40.1.7	Yes	7 business days of reply listing
Request to Decline Part D (Exh. 29)	40.1.6 40.1.7	Yes	7 business days of request

## Appendix 2: Data Elements Required to Complete the Enrollment Election

(REVISED 08-05)

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.

	<b>Data Element</b>	<b>Required before enrollment complete?</b>	<b>Exhibit # in which data element appears</b>
1	MA Plan name	Yes	1, 2, 3, 3a
2	MA Plan/Product/premium choice (if included)	Yes	1, 2, 3a
3	Beneficiary name	Yes	1, 2, 3, 3a
4	Beneficiary Date of Birth	Yes	1, 2
5	Beneficiary Sex	Yes	1, 2
6	Social Security Number	No	1,2
7	Beneficiary Telephone Number	No	1, 2, 3
8	Permanent Residence Address	Yes	1, 2, 3
9	Mailing Address	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	E-mail Address	No	1,2,3
12	Beneficiary Medicare number	Yes	1, 2, 3
13	Additional Medicare information contained on sample Medicare card, or copy of card	No <sup>2</sup>	1, 2
14	Plan Premium Payment Option	Yes	1,3,3a
15	Response to ESRD Question	Yes	1, 2
16	Response to long term care question	No	1, 2
17	Response to other insurance COB information	Yes	1, 2

<sup>2</sup> As stated in §40.2, an MA organization can 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 MA organization has obtained evidence of entitlement to Medicare Part A and enrollment in Part B. We recognize that the MA 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.

<b>Data Element</b>		<b>Required before enrollment complete?</b>	<b>Exhibit # in which data element appears</b>
18	Response to Medicaid question	No	1, 2
19	Language preferences (Optional Field)	No	1, 2
20	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	2
21	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No	2
22	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	2
23	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No	1, 2, 3
24	Beneficiary signature and/or Authorized Representative Signature	Yes <sup>3</sup>	1, 2, 3,3a
25	Date of signature	No <sup>4</sup>	1, 2, 3, 3a
26	Authorized representative contact information	Yes	1,2,3, 3a
27	Employer Name and Group Number	Yes	2
28	Question of which MA plan/premium the beneficiary is currently a member of and to which MA plan/premium the beneficiary is changing	Yes	3
29	Information regarding creditable coverage	Coming Fall 2006	

<sup>3</sup> For Employer Group MA enrollment elections as described in §40.4.1, and some other CMS approved enrollment elections, a signature is not required.

<sup>4</sup> As explained in §40.2, the beneficiary and/or legal representative should write the date s/he signed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment form, then the stamped date of receipt that the MA organization places on the enrollment form may serve as the signature date of the form. Therefore, the signature date is not a necessary element. For employer group MA elections as described in §40.4.1, the "signature date" is the date the employer's process was completed as recorded.

## **Chapter 2**

# **EXHIBITS:**




Model Medicare Advantage Enrollment Form & Notices



**Exhibit 1: Model MA Individual Enrollment Form (“Election” may also be used)**

**(REVISED 8-05)**

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

<b>To Enroll in &lt;plan&gt;, Please Provide the Following Information:</b>																																											
[Optional Field] <b>Please check which plan you want to enroll in:</b> ____ Product ABC \$XX per month      ____ Product XYZ \$XX per month																																											
LAST name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.																																								
Birth Date: ( __ / __ / __ __ ) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: <i>(providing this information is optional)</i>	Home Phone Number: (    )																																								
Permanent Residence Street Address:																																											
City:	State:	ZIP Code:																																									
<b>Mailing Address</b> (only if different from your Permanent Residence Address):																																											
Street Address:	City:	State:	ZIP Code:																																								
<b>Emergency contact:</b> [Optional field] _____																																											
<b>Phone Number:</b> [Optional field] _____ <b>Relationship to You</b> [Optional field] _____																																											
[optional field] <b>E-mail Address:</b> _____																																											
<b>Please Provide Your Medicare Insurance Information</b>																																											
<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> <li>Please fill in these blanks so they match your red, white and blue Medicare card</li> <li>- OR -</li> <li>Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #cccccc;"> <td colspan="2" style="text-align: center; padding: 5px;"><b>MEDICARE</b></td> <td style="text-align: center; padding: 5px;"></td> <td colspan="2" style="text-align: center; padding: 5px;"><b>HEALTH INSURANCE</b></td> </tr> <tr style="background-color: #cccccc;"> <td colspan="5" style="text-align: center; padding: 5px;">SAMPLE ONLY</td> </tr> <tr> <td colspan="5" style="padding: 5px;">Name: _____</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Medicare Claim Number</td> <td colspan="2" style="padding: 5px;">Sex ____</td> </tr> <tr> <td colspan="5" style="padding: 5px;">_____ - _____ - _____</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Is Entitled To</td> <td colspan="2" style="padding: 5px;">Effective Date</td> </tr> <tr> <td colspan="3" style="padding: 5px;"><b>HOSPITAL (Part A)</b></td> <td colspan="2" style="padding: 5px;">_____</td> </tr> <tr> <td colspan="3" style="padding: 5px;"><b>MEDICAL (Part B)</b></td> <td colspan="2" style="padding: 5px;">_____</td> </tr> </table>			<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>		SAMPLE ONLY					Name: _____					Medicare Claim Number			Sex ____		_____ - _____ - _____					Is Entitled To			Effective Date		<b>HOSPITAL (Part A)</b>			_____		<b>MEDICAL (Part B)</b>			_____	
<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>																																								
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<b>HOSPITAL (Part A)</b>			_____																																								
<b>MEDICAL (Part B)</b>			_____																																								

### Your Plan Premium Option

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). *<Optional – insert other billing interval options, if available>* Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**Would you like the premium for this plan deducted from your SSA monthly benefit check.**  Yes  No

#### Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)?  Yes  No

If you answered "yes" to this question and 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. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <MA plan>?  Yes  No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: \_\_\_\_\_ ID # for this coverage: \_\_\_\_\_ Group # for this coverage \_\_\_\_\_

3. Are you a resident in a long-term care facility, such as a nursing home?  Yes  No

If "yes" please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone Number of Institution (number and street): \_\_\_\_\_

4. Are you enrolled in your State Medicaid program?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

5. Do you or your spouse work?  Yes  No

**[Optional field ] Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):**

**[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., Spanish)

\_\_\_ Language B (e.g., Chinese)



### Please Read This Important Information

**If you currently have health coverage from an employer or union, joining <MA-PD Name> could affect your employer or union health benefits.** If you have health coverage from an employer or union, joining <MA-PD Name> may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

### Please Read and Sign Below:

**By completing this enrollment application, I agree to the following:**

<Name> is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Name> or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

<Name> serves a specific service area. If I move out of the area that <Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from [name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

[MA PFFS do not include the following paragraph] I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from [name of plan], with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR [NAME OF PLAN] WILL PAY FOR THE SERVICES.**

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <MA Plan> or by Medicare.

**Your Signature:**

**Today's Date:**

If you are the authorized representative, you must provide the following information:

**Name :** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Relationship to Enrollee** \_\_\_\_\_

**Office Use Only:**

Name of staff member (if assisted in enrollment): \_\_\_\_\_

Plan ID #: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

ICEP/IEP: \_\_\_\_\_ OEP: \_\_\_\_\_ AEP: \_\_\_\_\_ SEP (type): \_\_\_\_\_

**Exhibit 2: Model Employer Group Health Plan Enrollment Form (“Election” may also be used)**

**(REVISED 8-05)**

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

**To Enroll in <plan>, Please Provide the following Information:**

Employer Name:	Group #:
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[Optional Field] **Please check which plan you want to enroll in:**  
 \_\_\_ Product ABC \$XX per month      \_\_\_ Product XYZ \$XX per month

LAST name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
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Birth Date: (__/__/____) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: (providing this information is optional)	Home Phone Number: (    )
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Permanent Residence Street Address:

City:	State:	ZIP Code:
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**Mailing Address** (only if different from your Permanent Residence Address):

Street Address:	City:	State:	ZIP Code:
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[optional field] **E-mail Address:**

**Please Provide Your Medicare Insurance Information**

<p>Please take out your Medicare Card to complete this section.</p> <ul style="list-style-type: none"> <li>Please fill in these blanks so they match your red, white and blue Medicare card</li> <li>- OR -</li> <li>Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.</li> </ul> <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>	<div style="border: 1px solid black; padding: 5px;"> <div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;"> </div> <p style="text-align: center; margin: 0;">SAMPLE ONLY</p> <p>Name: _____</p> <p>Medicare Claim Number      Sex _____</p> <p>_____ - _____ - _____</p> <p>Is Entitled To      Effective Date</p> <p><b>HOSPITAL (Part A)</b>      _____</p> <p><b>MEDICAL (Part B)</b>      _____</p> </div>
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**Please read and answer these important questions:**

1. Are you the retiree?  Yes  No

If yes, retirement date (month/date/year): \_\_\_\_\_

If no, name of retiree: \_\_\_\_\_

2. Are you covering a spouse or dependents under this employer plan?  Yes  No

If yes, name of spouse: \_\_\_\_\_

Name of dependents: \_\_\_\_\_

3. Do you or your spouse work?  Yes  No

4. Do you have End Stage Renal Disease (ESRD)?  Yes  No

If you answered “yes” to this question and 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.

4. Some individuals may have other drug coverage, including other private insurance, Worker’s Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <PDP plan>?  Yes  No

If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: \_\_\_\_\_

ID # for Coverage: \_\_\_\_\_

5. Are you a resident in a long-term care facility, such as a nursing home?  Yes  No

If “yes” please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone Number of Institution (number and street): \_\_\_\_\_

6. Do you receive Medicaid benefits?  Yes  No

If yes, please provide your Medicaid number: \_\_\_\_\_

[Optional field] **Please Choose the Name of chosen Primary Care Physician (PCP), clinic or health center (if required):**

*[This field is not necessary for PPOs]*

[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)

**Please Read and Sign Below:**

**By completing this enrollment application, I agree to the following:**

<Name> is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.] Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Name> or by calling

1-800-Medicare. TTY users should call 1-877-486-2048.

<Name> serves a specific service area. If I move out of the area that <Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from [name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

[MA PFFS do not include the following paragraph] I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from [name of plan], with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR [NAME OF PLAN] WILL PAY FOR THE SERVICES.**

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <Name> or by Medicare.

<b>Your Signature:</b>	<b>Today's Date:</b>
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If you are the authorized representative, you must provide the following information:

**Name :** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Relationship to Enrollee** \_\_\_\_\_

<b>Office Use Only:</b> Name of staff member (if assisted in enrollment): _____ Plan ID #: _____ Effective Date of Coverage: _____ ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____
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### Exhibit 3: Model Short Enrollment Form (“Election” may also be used)

This form may be used in place of the model individual enrollment form when a member of a MA plan is enrolling into another MA plan in the same MAO

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

<b>Name of Plan You are Enrolling In:</b> _____		
<b>Name:</b> _____	<b>Medicare Number:</b> _____ (Note: may use “member number” instead of “Medicare number”)	
Home Phone Number: _____		
Permanent Street Address _____		
City: _____	State: _____	ZIP Code: _____
<b>Mailing Address</b> (only if different from your Permanent Street Address):		
Street Address: _____	City: _____	State: _____ ZIP Code: _____
<b>Please fill out the following:</b>		
I am currently a member of the _____ plan in _____ {MAO name} with a monthly premium of \$_____ .		
I would like to change to the _____ plan in _____ {MAO name}. I understand that this plan has different health benefits and a monthly premium of \$_____ .		
<b>Name of chosen Primary Care Physician (PCP), clinic or health center (if required):</b> Optional field, if MAO will require the member to name a new PCP:		

#### Your Plan Premium Option

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). **<Optional – insert other billing interval options, if available>** Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**Would you like the premium for this plan deducted from your SSA monthly benefit check.**  Yes  No

#### Please Read and Sign Below:

**Release of Information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.



[MA PFFS do not include the following paragraph] I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from [name of plan], with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR [NAME OF PLAN] WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <Name> or by Medicare.

<b>Your Signature:</b>	<b>Today's Date:</b>
------------------------	----------------------

If you are the authorized representative, you must provide the following information:

**Name :** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone Number:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
**Relationship to Enrollee** \_\_\_\_\_

<p><b>Office Use Only:</b>  Name of staff member (if assisted in enrollment): _____  Plan ID #: _____  Effective Date of Coverage: _____  ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____</p>
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## **Exhibit 3a: Model Selection Form for MA-PD - Switch From Plan to Plan Within MA Organization**

**(REVISED 8-05)**

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

Dear <plan name> Member:

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

To make a change in the Medicare Advantage plan you have with <name of MAO>, fill out the enclosed plan benefit selection form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us <optional: in the postage-paid envelope> by <date>.

Please be aware that you can change health plans only at certain times during the year. Between November 15, 2005 and May 15, 2006, anyone can join our plan.

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 the attached form only if you wish to change plans.

To help you with your decision, we have also included <year> <summary of benefits or benefit overview> for the available options.

If you have any questions, please call 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 want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

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

\_\_\_\_\_ <Name of Plan>  
<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. )

### Your Plan Premium Option

You can have the monthly premium for this Medicare drug plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). **<Optional – insert other billing interval options, if available>** Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

**Would you like the premium for this plan deducted from your SSA monthly benefit check?**  Yes  No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please mail this form to:**

**<Insert mailing address>**

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

(REVISED 8-05)

Referenced in section(s): 40.4.1, 60.4

[Member # - if member # is SSN, only use last 4 digits]

[RxID]

[RxGroup]

[RxBin]

[RxPCM]

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <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 your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. [**Optional language:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

[MA PPO should use the following paragraph in place of 1<sup>st</sup> paragraph above:]

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must receive your health care as provided in your [*insert either "Member handbook" or "evidence of coverage"*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. [**Optional language:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

[MA PFFS plans should use the following paragraph in place of 1<sup>st</sup> paragraph above:]

Thank you for enrolling in <Plan name>. Beginning <effective date>, you will begin to receive your healthcare from <plan>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment, as provided in your [*insert either "Member handbook" or "evidence of coverage"*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. [**Optional language:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

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 <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.

*[MA plans without a premium – do not use the following paragraph]* If you have chosen to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. Generally you must stay with the option you choose for the rest of the year. If you did not choose this option, we will send you a bill each month for your monthly premium.

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've received.

*[MA PPO and PFFS plans do not use the following paragraph]* Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services**, if you get health care services from a non-<Plan> doctor without prior authorization, you will have to pay for these services yourself.

Once enrolled in our plan, you can only make changes during certain times of the year. *[Plans open for the OEP in 2006, insert the following:* Between January and June, you have an opportunity to make changes, but you can only join a plan that has prescription drug coverage or does not have prescription drug coverage, depending on whether you have such coverage.] Between November 15, 2005, and May 15, 2006, anyone can make any type of change. If you have more questions about this, please feel free to call our member services department at phone number.

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

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 MA Organization

(REVISED 08-05)

Referenced in section(s): 40.4.1, 60.4

[Member # - if member # is SSN, only use last 4 digits]

[RxID]

[RxGroup]

[RxBin]

[RxPCM]

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 your plan copayments at the time you get health care services. [*Optional language:* This letter is proof of insurance that you should show during your doctor's appointments. ]

[*MA PPO should use the following paragraph in place of 1<sup>st</sup> paragraph above:*]

Thank you for your request to change your enrollment from <old Plan name> to <new plan name>. Beginning <effective date>, you must receive your health care as provided in your [*insert either "Member handbook" or "evidence of coverage"*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. [**Optional language:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

[*MA PFFS plans should use the following paragraph in place of 1<sup>st</sup> paragraph above:*

Thank you for your request to change your enrollment from <old Plan name> to <new plan name>. Beginning <effective date>, you will begin to receive your healthcare from <plan>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you are and accept our plan's terms of payment, as provided in your [*insert either "Member handbook" or "evidence of coverage"*]. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. [**Optional language:** This letter is proof of insurance that you should show during your doctor' appointments until you get your member card from us.]

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>.

*[MA plans without a premium – do not use the following paragraph]* If you have chosen to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. Generally you must stay with the option you choose for the rest of the year. If you did not choose this option, we will send you a bill each month for your monthly premium.

*[MA PPO and PFFS plans do not use the following paragraph]* Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services**, if you get health care services from a non-<new Plan> doctor without prior authorization, you will have to pay for these services care yourself.

Once enrolled in our plan, you can only make changes during certain times of the year. *[Plans open for the OEP in 2006, insert the following:* Between January and June, you have an opportunity to make changes, but you can only join a plan that has prescription drug coverage or does not have prescription drug coverage, depending on whether you have such coverage.] Between November 15, 2005, and May 15, 2006, anyone can make any type of change. If you have more questions about this, please feel free to call our member services department at phone number.

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

(REVISED 08-05)

Referenced in section(s): 40.2.2

Dear <Name of Member>:

Thank you for applying with <MA 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.

\_\_\_\_\_ Other: \_\_\_\_\_

You will need to send this information to <MA Plan name and address> by <date>. If you cannot send this information by this date, 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

(REVISED 08-05)

Referenced in section(s): 40.40.2, 40.6

[Member # - if member # is SSN, only use last 4 digits]

[RxID]

[RxGroup]

[RxBin]

[RxPCM]

Dear <Name of Member>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <MA Plan> beginning <effective date>.

*[MA-PD insert the following if no low-income subsidy: The premium for your plan is: [insert premium].*

*[MA-PD, if low-income subsidy applicable:] Because you qualify for extra help with your prescription drug costs, you will pay:*

- [insert premium less amount of premium assistance for which the individual is eligible],
- [insert either \$0 or \$50] for your yearly prescription drug plan deductible,
- [insert copay amount: \$0, \$1/\$3, \$2/\$5, or 15%] copayment when you fill a prescription.

Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. (Please note that if this is the first time that you are a member of a Medicare Health Plan (Medicare Advantage or Medicare Cost plan), you may have a trial period during which you have certain rights to *leave* (disenroll from) <MA 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 - Plan to Plan Within MA Organization**

**(Rev 8-05)**

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has approved your enrollment in <MA Plan> beginning <effective date>.

*[MA-PD insert the following if no low-income subsidy: The premium for your plan is: [insert premium].*

*[MA-PD, if low-income subsidy applicable:] Because you qualify for extra help with your prescription drug costs, you will pay:*

- [insert premium less amount of premium assistance for which the individual is eligible],
- [insert either \$0 or \$50] for your yearly prescription drug plan deductible,
- [insert copay amount: \$0, \$1/\$3, \$2/\$5, or 15%] copayment when you fill a prescription.

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 6b: Model Notice for MA-PD Plans for Individuals Identified on CMS Records As Members of Employer Group Receiving Subsidy**

(NEW)

Referenced in section(s): 40

Dear <Name of Member>:

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

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has informed us you belong to an employer group health plan whose drug coverage is as good as the Medicare prescription drug plan.

It is important that you consider your decision to enroll in our plan carefully, since enrollment in <plan> could affect your employer health benefits. If you have not already done so, please contact your benefits administrator to discuss your decision to enroll in a Medicare prescription drug plan.

If you have already discussed this decision with your benefits administrator and have decided that you would still like to be a member of <plan>, **please confirm this by calling our members services department at phone number**>. TTY users should call <TTY number>. Your enrollment will not be complete until you call and confirm this information. Your effective date will be the 1<sup>st</sup> of the month after we hear from you.

We must hear from you to enroll you in our plan - if we do not hear from you within 30 days from the date of this notice, we will not process your enrollment.

If you have any questions, please feel free to contact us at < number>. We are open {insert days/hours of operation and, if different, TTY hours of operation}.

Thank you.

## Exhibit 7: Model Notice for MA Organization Denial of Enrollment

(REV 8-05)

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

Thank you for applying with <MA Plan>. We cannot accept your request for enrollment in <MA Plan> because:

1. \_\_\_\_\_ You 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. \_\_\_\_\_ You attempted to enroll outside of an enrollment period.
6. \_\_\_\_\_ You are not eligible to enroll in prescription drug coverage at this time.
7. \_\_\_\_\_ We did not receive the information we requested from you within the timeframe listed in our request.

If this information is correct, then we may send you a bill for any services you may have already received.

If item 5 is checked, remember that you can make changes only at certain times during the year. *[Plans open for the OEP in 2006, insert the following: Between January and June, you have an opportunity to make changes, but you can only join a plan that has prescription drug coverage or does not have prescription drug coverage, depending on whether you have such coverage.]* Between November 15, 2005, and May 15, 2006, anyone can make any type of change. If you have more questions about this, please feel free to call our member services department at phone number.

If any of the checked items 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>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <MA 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 attempted to enroll outside of an enrollment period.
5. \_\_\_\_\_ You requested to enroll in a different plan for the same effective date, which canceled your application with <MA Plan>. This may mean that you are still enrolled in the Original Medicare Plan or in the Medicare Health Plan (Medicare Advantage or Medicare Cost plan) that you were enrolled in before you applied for membership in our plan.

If this information is correct, we may send you a bill for any services you may have already received.

If any of the checked items 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 08-05)

Referenced in section(s): 50.1

Dear <Name of Member>:

Attached is the disenrollment form you requested. Fill out this disenrollment form if you would like to disenroll from our plan to Original Medicare. Beginning in 2006, you can make plan changes only at certain times during the year. In 2006, you can disenroll between January and June, 2006. However, the way you disenroll depends on type of prescription drug coverage you have through our plan.

Please read the important information below regarding these changes.

DO NOT FILL OUT THE ATTACHED FORM IF:

- 1) You are planning to enroll, or have enrolled in another Medicare Advantage or other Medicare Health Plan. Enrolling in another Medicare plan will automatically disenroll you from our plan.

OR

- 2) You are enrolling in a Medicare prescription drug plan. Enrolling in such a plan will automatically disenroll you from our plan to Original Medicare. **If you have prescription drug coverage through our plan**, you must enroll in a Medicare prescription drug plan.

*[MA PFFS without drugs use the following in place of the above paragraph:*

**DO NOT FILL OUT THE ATTACHED FORM IF** you are planning to enroll, or have enrolled in, another Medicare Advantage or other Medicare Health Plan. **If you have prescription drug coverage through our plan**, you must enroll in a Medicare prescription drug plan.]

Until your disenrollment date, you must keep using <MA Plan> doctors. To avoid any unexpected expenses, you may want to contact us to make sure you've been disenrolled before you seek medical services outside of <MA plan>'s network.

If you do NOT have prescription drug coverage through our plan, you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can also call 1-800-MEDICARE (1-800-633-4227). For information about drug plans available in your area. TTY users should call 1-877-486-2048.

## A 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. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact 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.

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 08-05)

Referenced in section(s): 10

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

Last name:	First Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Ms.
Medicare #			
Birth Date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: (    )	

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

On the effective date of enrollment in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will automatically cancel my current membership in <MA plan name>. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and do not enroll in such coverage at this time, I may have to pay a higher premium for this coverage in the future.

**Your Signature\*:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by <plan name> by Medicare.

If you are the authorized representative, you must provide the following information:

**Name :** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_- \_\_\_\_

**Relationship to Enrollee** \_\_\_\_\_



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

**(REV 08-05)**

Referenced in section(s): 50.1, 50.4.1

Dear <Name of Beneficiary>:

We received your request to disenroll from <MA Plan>. You will be disenrolled starting <effective date.> Beginning <effective date>, <MA Plan> will not cover any health care you receive. Beginning <effective date>, you can see any doctor through the Original Medicare Plan, unless you have enrolled in another Medicare Advantage 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 <MA Plan> and there may be a short delay in updating your records.

### **A 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. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact 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.

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 08-05)**

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

Dear <Name of Beneficiary>:

The Centers for Medicare & Medicaid Services, the federal agency that runs the Medicare program, has confirmed your disenrollment from <MA Plan>. Beginning <effective date,> <MA Plan> will not cover any health care you receive. If your doctor needs to send Medicare claims, you may want to tell them that there may be a short delay in updating your records since you just disenrolled from <MA Plan>.

### **A 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. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact 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.

If you think you did not disenroll from <MA 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 12a: Model Notice for MA Organization Denial of Disenrollment

(New)

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

We recently received your request to disenroll from <MA Plan>. We cannot accept your request for disenrollment because:

1. \_\_\_\_\_ You have attempted to make a change outside of an enrollment period.
2. \_\_\_\_\_ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

Beginning in 2006, there are limits to when and how often you can change the way you get Medicare.

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.
- **From November 15, 2005 and May 15, 2006**, anyone with Medicare can switch from one way of getting Medicare to another.

Generally, you may not make any other changes during the year unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

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

## Exhibit 12b: Model Notice for CMS Rejection of Disenrollment

(NEW)

Referenced in section(s): 50.1

Dear <Name of Beneficiary>:

The Centers for Medicare & Medicaid Services, the federal agency that runs Medicare, has denied your enrollment in <MA Plan> due to the reason(s) checked below:

1. \_\_\_\_\_ You have attempted to make a change outside of an enrollment period.
2. \_\_\_\_\_ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

Beginning in 2006, there are limits to when and how often you can change the way you get Medicare.

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.
- **From November 15 through December 31**, anyone with Medicare can switch from one way of getting Medicare to another for the following year.

Generally, you may not make any other changes during the year unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

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.

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 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 <MA Plan> has ended as of <effective date>. If membership premiums were paid for any month after <effective date>, we will issue a refund to 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>:

The Centers for Medicare & Medicaid Services (CMS) has told us that you no longer have Medicare Part <insert A and/or B, as appropriate>. You need to have coverage under both Medicare Part A and Part B to remain enrolled in a Medicare Advantage plan. Therefore, your membership in <MA Plan> ended on <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 as 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 <MA Plan> written proof at <address> after you do this. When we receive this proof, we will tell CMS to correct its records.

In the meantime, you should keep using your <MA Plan> primary care physician for your health care. **(Note: If PCP not applicable, omit this sentence. MA 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 <MA 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 <MA Plan>. To do this, please complete the following steps:

1. Contact the Social Security Administration (SSA) at 1-800-772-1213 between 7AM to 7PM, Monday to Friday, to have them fix their records TTY users should call 1-800-325-0778.
2. Ask SSA to give you a letter that says they have fixed your records.
3. Send the letter from SSA to us at: <address of MA Plan> in the enclosed postage-paid envelope. You may also fax this information to us at [insert fax number]. 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 <MA Plan> primary care physician for your health care. **(Note: If PCP not applicable, omit this sentence. MA 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 <MA Plan>.



## **Exhibit 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another MA Organization**

**(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 remain a member of <MA 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 <MA 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 <MA Plan>. Your letter must also say whether or not you got services from non- <MA Plan> doctors since <original effective date of disenrollment>. If you did not get any services from non- <MA 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 <MA Plan> primary care physician for your health care.**(Note: If PCP not applicable, omit this sentence. MA 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 <MA 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 <MA 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 8-05)**

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>.

**MA organizations who will disenroll all members (and not use the downgrade option) use the following sentence:** If we do not receive payment by <insert premium due date>, we will have to disenroll you from <MA Plan>, effective <insert disenrollment date>. After the disenrollment you will be covered by the Original Medicare Plan instead of <MA Plan>.

**Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent disenrollment.**

**MA organizations who will 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 <MA plan name> that will reduce the amount of health care coverage you have in <MA plan name>. This means that (describe lower level of benefits, e.g., routine dental care will not be covered) beginning <date>.

**Note: As required in section 50.3.1, the MA organization must state whether full payment of premiums is due to prevent the downgrade.**

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, your plan premium. If you are no longer eligible for assistance from Medicaid, you may have a special temporary right to buy a Medigap policy if you voluntarily disenroll from our plan. If you have questions, 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 <MA Plan> and change to the Original Medicare Plan now, you should do one of these three things:

1. Send us a written request at <MA Plan address>.
2. Call 1-800-MEDICARE(1-800-633-4227). TTY users should call 1-877-486-2048.

Remember, beginning in 2006, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.
- **From November 15, 2005, through May 15, 2006**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

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 8-05)**

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 <MA Plan>. Since we did not receive that payment, we asked the Centers for Medicare & Medicaid Services (CMS) to disenroll you from <MA Plan> beginning <date>.

**Due to your disenrollment from <MA Plan>, you will be 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 [insert "Member Handbook" or "Evidence of Coverage", as appropriate].

*[MA PFFS do not include this paragraph]* Please note that until <disenrollment effective date>, you must keep using <MA 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 Medicare Advantage or another Medicare health plan.

Once in Original Medicare, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.
- **From November 15, 2005, through May 15, 2006**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

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 8-05)**

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 <MA Plan> due to non-payment of plan premium. Your disenrollment begins <effective date>.

Due to your disenrollment from <MA Plan>, you are now enrolled in the Original Medicare plan. As mentioned in our previous letter to you, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.
- **From November 15, 2005, through May 15, 2006**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

You have the right to ask us to reconsider your disenrollment through the grievance procedure written in your [insert "Member Handbook" or "Evidence of Coverage", as appropriate].

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 Within Plan**

**(REV 8-05)**

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 <MA Plan>. Our records show that we did not get payment from you as of <Date>. Therefore, we have reduced your coverage in <MA Plan>, beginning <effective date>.

<Explain in simple terms lower level of benefits, e.g., routine dental care will not be covered>

You have the right to ask us to reconsider this change through the grievance procedure written in your [insert "Member Handbook" or "Evidence of Coverage", as appropriate].

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

1. Send us your written request to <MA Plan or fax it to us at <fax number>.
2. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (1-800-633-4227).

Remember, beginning in 2006, there are limits to when and how often you can change the way you get Medicare:

- **From January 1, 2006 until June 30, 2006**, anyone with Medicare (including members of [Plan Name]) has one opportunity to make a change in the way they get Medicare.
- **From November 15, 2005, through May 15, 2006**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you will only be able to make changes during these two times, unless you meet certain special exceptions, such as if you move out of the plan's service area or if you have Medicare coverage.

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 Due to Capacity Limits**

**(REV 8-05)**

Referenced in section(s): 30

[Insert name of MA organization] PUBLIC NOTICE

As of [insert date], [insert name of MA organization] will no longer accept enrollment under its Medicare Advantage 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 Advantage 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 MA 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 <MA 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 Advantage 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 8-05)**

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 <MA Plan> primary care physician for your health care.

**(Note: If PCP not applicable, omit this sentence. MA 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 <MA Plan>.

If you have also submitted an enrollment to another Medicare Health Plan (Medicare Advantage Plan or Medicare Cost Plan) or Medicare Prescription Drug Plan, you may appear on their records as being enrolled. If your intent is NOT to enroll with that plan and stay enrolled in <our plan>, you will need to notify them that you are canceling enrollment in their plan before that enrollment takes effect. They may request you write them a letter for their records.

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

**Exhibit 27: MA Model Notice to Inform Dually Eligible Member of Auto-Enrollment in MA-PD**  
(NEW)

Referenced in section: 40.1.6

[Member # - if member # is SSN, only use last 4 digits]  
[RxID]  
[RxGroup]  
[RxBin]  
[RxPCM]

Dear <insert member name>

Our records show that you have Medicare and Medicaid and your Medicaid prescription drug coverage is ending. To make sure that you don't lose a day of your drug coverage, Medicare is enrolling you in our <name of MA-PD plan> that offers Medicare prescription drug coverage, beginning <effective date>.

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.

With the addition of this Medicare prescription drug coverage, you will pay:

- \$0 for your yearly prescription drug plan deductible,
- [insert copay amount \$0, up to \$1 and \$3, or up to \$2 and \$5] copayments when you fill a prescription.

[Include cost of premium less low-income premium subsidy amount, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.

[MA PPO and PFFS plans do not use the following paragraph] Please remember that, except for emergency or out-of-area urgent care, **or out-of-area dialysis services**, if you get health care from a non-<new Plan> doctor without prior authorization, you will have to pay for the health care yourself.

Remember, your Medicaid prescription drug coverage is ending. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover those prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like [plan name].

You are not required to be in our Medicare prescription drug plan and have the option to stay in [insert name of MA-only plan]. If you decide not to be enrolled and don't have other drug coverage at least as good as Medicare prescription drug coverage, you may have to pay more for this coverage at a later time. If you don't want Medicare prescription drug coverage, 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}. You will need to tell us you don't want Medicare prescription drug coverage.  
Thank you.

## Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment

(NEW)

Referenced in section: 40.1.7

[Member # - if member # is SSN, only use last 4 digits]

[RxID]

[RxGroup]

[RxBin]

[RxPCM]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs. Medicare is helping you enroll in our <name of MA-PD plan> that offers Medicare prescription drug coverage, beginning <effective date>. This way, you will pay the lowest possible premium for Medicare prescription drug coverage.

*[MA PPO and PFFS plans do not use the following paragraph]* Starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <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.

With the addition of this Medicare prescription drug coverage, you will pay:

- [insert either \$0 or \$50] for your yearly prescription drug plan deductible,
- [insert copay amount: up to \$2 and \$5; or 15%] copayments when you fill a prescription.

[Include cost of premium less amount of premium assistance the member is eligible for, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.

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.

You are not required to be in our Medicare prescription drug plan and have the option to stay in [insert name of MA-only plan]. If you decide not to be enrolled and don't have other drug coverage at least as good as Medicare prescription drug coverage, you may have to pay more for this coverage at a later time. If you don't want Medicare prescription drug coverage, 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}. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

## **Exhibit 29: Acknowledgement of Request to Decline Part D**

**(NEW)**

Referenced in section(s): 40.1.6 and 40.1.7

Dear <name of member>:

As requested, we have processed your request to decline Medicare prescription drug coverage. You will continue to be a member of <MA Plan> that does not offer Medicare prescription drug coverage.

If you had Medicaid drug coverage, it will no longer pay for your prescription drugs. Our records show you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.

Remember, even if you don't use a lot of prescription drugs now, you still should consider signing up for a Medicare prescription drug plan. For most people, joining now means you will pay your lowest possible monthly premium. If you don't join a plan by May 15, 2006, and you don't currently have prescription drug coverage that covers at least as much as Medicare prescription drug coverage, your premium cost will go up at least 1% per month for every month that you wait to enroll. You will have to pay this penalty as long as you have Medicare prescription drug coverage.

If you change your mind now or at anytime in the future, you can call <MA Plan> customer service at <number>, Monday through Friday between the hours of <hours>. TTY users should call [insert TTY number].