**Model Letter to Beneficiaries Who Could Not be Reached for Verification by Phone**

[Date]

[Member #]

[RxID]

[RxGroup]

[RxBin]

[RxPCN]

Dear [first and last name of applicant]:

We have received your application to enroll in [**Insert:** plan name and type of plan (all but HMOs spell out the type of plan in addition to giving the acronym, e.g., “Private Fee-For-Service (PFFS)], which is a [**Insert whichever is applicable:** *Medicare Advantage Plan or Medicare Advantage Prescription Drug Plan or Medicare Prescription Drug Plan or Medicare Cost Plan or Medicare Medical Savings Account*]. [**Insert for Medicare health plans:** Enrolling in [plan name] means that you will be getting your Medicare coverage through [plan name]. [Plan name] is not Original Medicare and it is not a Medigap or Medicare supplemental insurance plan].

Please review this letter carefully – it has important information about how our plan works and how you can [**Insert for Medicare health plans:** ***<get care or Medicare Prescription Drug plans> or <get prescription drugs>*].** Because [plan name] is a [**Insert type of plan;** all but HMOs spell out the type of plan in addition to giving the acronym, e.g., “Private Fee-For-Service (PFFS)], it has some special rules that you will need to follow. We want to make sure you understand these rules before your enrollment becomes final.

At the end of this letter, we tell you:

* How to contact us by telephone if you have questions.
* What happens next in processing your enrollment in our plan.
* What to do if you change your mind about enrolling in our plan (the deadline for cancelling your enrollment is

[**Insert this language when the enrollment received is not part of the Annual Election Period (AEP) enrollment requests:** date must be either 7 calendar days from the date of this letter or the last day of the month in which the enrollment request was received, whichever comes later.]

**[Insert this language when the enrollment received is part of the Annual Election Period (AEP) enrollment requests** (except MSAs): December 31.

**Insert for Medicare MSA only:** date must be either 7 calendar days from the date of this letter or December 15 to cancel your enrollment.]

It’s a good idea to share this letter with people who help you make important decisions, such as your spouse, children, trusted friends, or your doctor.

**Important things to know about getting your Medicare as a member of our plan**

Below are some important things to know about getting the care and services you need while you are a member of our plan: Make sure you understand and accept the rules explained below.

**[All plans must include the language that follows for showing the membership card, cost sharing, and providers to use**]

**Show your [plan name] membership card before you get any [Insert *health care services* or *prescription drugs*]**

Enrolling in [plan name] means that you will be getting your [**Insert** *Medicare coverage, Medicare prescription drug coverage, or Prescription drug coverage*] through [plan name]. Once you are enrolled in our plan, we will send you a [plan name] membership card. You must use this card whenever you get [**Insert one of the following:** *health care services or prescription drugs]*. [**All but cost plans insert:** *Otherwise, your care might not be covered and you’ll have to pay the full cost yourself.*]

[**All but cost plans insert**: During the time you are a member of our plan, you must not use your red, white and blue Medicare card (unless you are receiving hospice services or getting care in a clinical research study). The red, white and blue Medicare card is used by people getting their Medicare coverage through Original Medicare, and our plan is different from Original Medicare.

You should keep your red, white and blue Medicare card in a safe place because you will need it later on if you return to Original Medicare. But during the time you are a member of [plan name], be sure to use only your [plan name] membership card. Otherwise, your [*health care services or prescription drugs*] might not be covered and you’ll have to pay the full cost yourself.]

[**Cost plans insert:** During the time you are a member of our plan you must see your [plan name] doctor(s) for your health care in order for the plan to fully cover your medical services. You may obtain medical services not provided or arranged by [plan name], but you will be responsible for payment of all Medicare deductibles and coinsurance, as well as any additional charges not covered by the Original Medicare program.]

**Know what you will have to pay as your share of the costs for the [health care services or prescription drugs] you receive**

As with any Medicare coverage, you will need to pay your share of the cost for services you receive. When you filled out the enrollment form, you should have received written information that tells what you must pay for services you receive as a member of [plan name]. If you need this information, please call us at [**Insert:** Member Services/Customer Service] [**Insert:** number and calling days and hours] or visit our website at [**Insert**: website information].

**Understand which [providers, pharmacies] you can use**

[**All PFFS plans** must include the following language**:**

[Plan name], the plan you are enrolling in, is a Private Fee-For-Service plan. When you are in this type of plan, you may get your covered Medicare services from any doctor, hospital, or other healthcare provider in the United States, as long as the provider agrees to accept our plan’s terms and conditions of payment before they provide services to you and the provider is eligible to furnish services under Original Medicare.

* The provider agrees to accept our plan’s terms and conditions of payment before they provide services to you
* *-- and --* the provider is eligible to provide services under Original Medicare.

To be sure that your care will be covered, you must tell your doctors and other providers that you are a member of [plan name] by showing them your [plan name] membership card. You must do this before you get any healthcare services and you must do it every single time you go. Here’s why:

* With a Private Fee-for-Service plan, doctors and other healthcare providers are allowed to decide each time you go in for care whether they want to accept or refuse [plan name]’s terms and conditions of payment. Even if a doctor accepted our plan the last time you went in for care, the doctor can refuse our plan the next time you go in.
* Emergency care is an exception to this rule. If it’s an emergency, you can get care without having the provider agree in advance to accept our plan’s terms and conditions of payment.
* To find out about our plan’s terms and conditions of payment, health care providers can use the [**Insert as applicable**: phone number or website and TTY number] on your plan membership card.
* If a provider has agreed to accept our plan’s terms and conditions of payment, the provider will bill [plan name] for the services you receive and you will pay your share of the costs of your care.
* If a provider does not accept [plan name]’s terms and conditions of payment, they should not provide services to you. In this case, you will need to find another provider that will accept our plan’s terms and conditions of payment.

**[Partial and full network PFFS plans include:]**

Our plan has signed contracts with some providers to deliver covered services to members in our plan. These providers have already agreed to see our members. These providers are our network providers. For the most up-to-date information on our network providers, you can either check our website or call [**Insert:** Member Services/Customer Service].

[**Full network PFFS plans include:]**

We have network providers for all services covered under Original Medicare [*indicate if network providers are available for any non-Medicare covered services*]. You can still receive covered services from out-of-network providers (those who do not have a signed contract with our plan), as long as those providers agree to accept our plan’s terms and conditions of payment. So, be sure to show your member ID card first to be sure they will accept our plan.

[**Partial network PFFS plans include:]**

We have network providers for [*indicate what category or categories of services for which network providers are available*]. You can still receive covered services from out-of-network providers (those who do not have a signed contract with our plan), as long as those providers agree to accept our plan’s terms and conditions of payment. For services for which network providers are not available, you can receive covered services from any provider who agrees to accept our plan’s terms and conditions of payment. So, be sure to show your member ID card first to be sure they will accept our plan.

[Partial and full network PFFS plans should describe whether or not the plan has established any higher cost sharing requirements if the member obtains a covered service from a deemed (out-of-network) provider.] [**Insert the following sentence if the plan includes such differential cost-sharing**: The amount of cost sharing you pay a provider who is not one of our network providers may be more than the cost sharing you pay a network provider.]

[**All HMO plan types** must include the following language:]

[Plan name], the plan you are enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other providers that provide healthcare services to members of our plan. You need to know which providers are part of our network because you [**Insert whichever** **is applicable:** must use *or* may be required to use] the providers who are in our network to get your healthcare services.

There are only four situations when [plan name] will cover healthcare services you get from providers who are not part of the plan’s network. These are:

* If you are having an emergency.
* If you have an urgent need for care and network providers are not available to give you this care.
* If you need kidney dialysis that is not available from the plan’s network.
* If you have asked for and received permission from [plan name] to use a provider who is not in the plan’s network.

[*HMO plans that offer a POS benefit can include the following along with a brief description of their POS benefit or a reference to where that information can be obtained.*] Under our point of service benefit we allow you to seek care from providers not in our network under certain conditions.

[**For SNPS only:** SNPs with arrangement with the State may revise this language to reflect, when applicable, that the organization is providing both Medicaid and Medicare covered benefits].

The health care providers in the plan’s network can change at any time. For the most up-to-date information on the network of providers, check our website or call [**Insert:** Member Services/Customer Service.]

[All **Cost Plans and PPOs** must include the following language:]

[Plan name], the plan you are enrolling in, is a [type of plan]. It has a network of doctors, specialists, hospitals, and other health care providers you can use to get your covered services. You can also use health care providers who are not in [plan name]’s network – however, your share of the costs for your covered services may be higher if you do.

The health care providers in the plan’s network can change at any time. For the most up-to-date information on the network of providers, check our website or call [**Insert:** Member Services/Customer Service.]

[All **Medicare Medical Savings Account** **Plans** must include the following language:]

[Plan name], the plan you are enrolling in, is a Medicare Medical Savings Account Plan (called an MSA). An MSA plan is a type of Medicare Advantage plan that combines a high-deductible health plan with a medical savings account. The plan will only begin to cover your costs once you meet the yearly deductible. You can choose to use the money in your savings account to help pay your health care costs before you meet your deductible. This type of plan gives you some control over your own health care dollars.

There are some important things to know while enrolled in an MSA plan:

The first part of a Medicare MSA plan is the high-deductible health plan.

* Your MSA plan has a yearly deductible of [**Insert:** deductible amount]. Until you have paid [**Insert:** deductible amount], you must pay the full cost of your covered services. Only Medicare Part A and Part B covered services count towards the MSA plan deductible.
* Even if you haven’t met your deductible yet, you should ask your provider to submit a claim to the plan. If your provider doesn’t submit a claim, you should report your expenses to the plan yourself to make sure that your expenses for Medicare services are counted toward your deductible.
* Once you meet your yearly deductible, the plan will pay 100% of the costs for covered Medicare services for the rest of the calendar year. Your MSA plan must cover the full cost of all Medicare Part A and Part B covered services.
* You should never be asked to pay more than the Medicare allowed amount for Medicare Part A or Part B covered services.
* The plan covers costs beyond an out-of-pocket spending limit (also known as catastrophic coverage).
* You do not pay a monthly premium to the plan to be a member of an MSA plan. However, you are still required to pay your monthly Medicare Part B premiums to Medicare.
* [**Insert, if appropriate:** [Plan name] has signed contracts with some providers to deliver covered services to members in our plan. These providers are our network providers. However, you are not required to use network providers. You can receive care from any provider in the United States who is eligible to provide services under Original Medicare.]

The second part of a Medicare MSA plan is the MSA account. The MSA account is a special type of savings account.

* An MSA account must be opened in your name as part of the enrollment process so that it can be funded with your yearly deposit.
* The plan deposits money from Medicare into the savings account at the beginning of each year. You cannot deposit your own money into the account.
* If you leave our plan in the middle of the year, part of the current year’s deposit will be refunded to Medicare. The amount recovered and refunded to Medicare depends on the number of months left in the current calendar year.
* You can use the money in your account to pay for medical expenses, but only Medicare Part A and Part B covered services count toward your deductible.
* To avoid taxes and penalties, you must use the money in your account for Qualified Medical Expenses. Qualified Medical Expenses are the same types of services and products that could be deducted as medical expenses on your yearly income tax return. (See IRS Publication 969). You need to keep track of your medical expenses during each calendar year.

You should also know that:

* MSAs do not offer Medicare Part D prescription drug coverage.
* You can join a stand-alone Medicare Prescription Drug Plan (PDP) to get Medicare Part D coverage. If you join a Medicare drug plan, any MSA account withdrawals you make to pay for Part D drug co-pays will count towards the drug plan’s out-of-pocket spending limit. However, these withdrawals will not count toward the MSA plan’s deductible.
* The Medicare Advantage Disenrollment Period (known as the MADP) which is from January 1 – February 14), applies to all other MA plans except for the MA MSA plans. MSA enrollees may not disenroll from their plan during that time due to the plan’s design, whereby an account deposit is made at the beginning of the year, and the beneficiary stays enrolled up to the point where they reach the plan deductible, and beyond during an entire calendar year.
* Note that Medigap policies do not work with Medicare Advantage plans, including MA MSA plans.

[All **PDPs** and all other plan types offering Part D coverage must include the following:]

[Plan name] has a network of pharmacies. In most situations, we will pay for your prescriptions only if you use a pharmacy in our network. To get more information, including the most up-to-date list of pharmacies in the plan’s network, you can either check our website or call [**Insert:** Member Services/Customer Service.]

If you have limited income and resources, you may be able to get extra help to pay for your prescription drug premiums and costs. To learn more and find out if you qualify for getting extra help, you can call any of these places:

* Medicare at 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
* The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778.
* Your State Medicaid Office at [**Insert:** contact information.]

**If you want to, you can cancel your enrollment in our plan**

If you do not want us to finish enrolling you as a new member, you can cancel your enrollment. If you do not want to become a new member of [plan name], you must call [plan name] [Member Services/Customer Service] at [phone number]. You can call [I**nsert:** calling hours and days of operation]. Tell the person who answers that you want to cancel your enrollment in [plan name].

The deadline for cancelling your enrollment is [**Insert one of the following**:

[**Insert this language when the enrollment received is not part of the Annual Election Period (AEP) enrollment requests:** date must be either 7 calendar days from the date of this letter or the last day of the month in which the enrollment request was received, whichever comes later.]

**[Insert this language when the enrollment received is part of the Annual Election Period (AEP) enrollment requests** (except MSAs): December 31.

**Insert for Medicare MSA only:** date must be either 7 calendar days from the date of this letter or December 15 to cancel your enrollment.]

If you decide you want to cancel your enrollment request and you don’t call us before [**Insert** date], we will not be able to cancel your enrollment. You may also call 1-800-Medicare for assistance in exploring other enrollment options.

**Otherwise, welcome to our plan!**

Unless you call to cancel your enrollment, we will continue processing your enrollment. You will receive a letter shortly with more information about your enrollment.

Sincerely [plans may use a different closing],

[Signature and title]

[Material Id]