

Medicare Advantage Enrollment and Disenrollment Guidance

Appendices and Exhibits

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Appendices

Summary of Medicare Advantage Notice and Data Element Requirements

Appendix 1: Summary of Notice Requirements

Referenced in sections: 10, 30, 40, 50, 60, and 70

This appendix is intended to be a summary of notice requirements. For exact detail on requirements and time frames, refer to the appropriate sections within the MA and Part D enrollment guidance.

Notice	Section(s)	Timeframe
Model Enrollment Form (Exh. 1) ¹	10, 40.1.1, 40.1.2, 50, 50.9.1	N/A
Information to include on or with Enrollment Mechanism -- Attestation of Eligibility for an Enrollment Period (Exh. 1a)	30.6, 50.2	N/A
MA MSA Enrollment Form (Exh 1b) ²	40	N/A
MA PFFS Enrollment Form (Exh 1c) ³	40	N/A
Simplified Enrollment Form (Exh. 1d)	40.1.7	N/A
EGHP Enrollment Form (Exh. 2)	10.2, 40, 50, 50.9.1	N/A
Short Enrollment Forms (Exh. 3 and 3a)	10, 40, 50, 50.9.1	N/A
Acknowledgment of Receipt of Completed Enrollment Request (Exh. 4 and 4a) ⁴	30, 50.9.1, 70.4	10 calendar days of receipt of completed enrollment request
Combination Acknowledgement and Confirmation Notice (Exh. 4b) ⁵	30, 50.9	7 calendar days of availability of the DTRR
Acknowledge Receipt of Completed PFFS Enrollment Request (Exh. 4c) ⁶	30, 50.9.1, 70.4	10 calendar days of receipt of completed enrollment request

¹ Other CMS approved enrollment election mechanisms may take the place of an enrollment form

² Other CMS approved enrollment election mechanisms may take the place of an enrollment form

³ Other CMS approved enrollment election mechanisms may take the place of an enrollment form

⁴ Required unless combined acknowledgment/confirmation notice is issued.

⁵ Required if the MAO has chosen to provide a single notice in response to the DTRR, as described in §50.9.1.

⁶ Required unless combined acknowledgment/confirmation notice is issued.

Notice	Section(s)	Timeframe
Notice to Acknowledge Receipt of Completed PFFS Enrollment Request and to Confirm Enrollment in a PFFS Plan (Exh. 4d)	30, 50.9.1, 70.4	7 calendar days of availability of the DTRR
Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment in Another Plan Within the Same Parent Organization (Exh. 4e)	30, 50.9	7 calendar days of the availability of the DTRR
Request for Information (Exh. 5)	30, 50.3	10 calendar days of receipt of enrollment request
Confirmation of Enrollment (Exh. 6, 6a, 6d) ⁷	50.9.2, 50.6	10 calendar days of availability of DTRR
Notice to Individuals Identified on CMS Records As Members of Employer or Union Group Receiving Retiree Drug Subsidy (Exh. 6b)	50.7	10 calendar days of availability of DTRR
Confirm PFFS Enrollment (Exh. 6c) ⁸	50.9.2	10 calendar days of availability of DTRR
MAO Denial of Enrollment (Exh. 7)	50.4, 50.7	10 calendar days of receipt of enrollment request OR expiration of time frame for requested additional information
CMS Rejection of Enrollment (Exh. 8)	50.9.2	10 calendar days of availability of DTRR (exception described in §40.4.2)
Sending Out Disenrollment Form/Disenrollment Form (Exh. 9, 9a, & 10)	60.1	N/A
Information to include on or with Disenrollment Form -- Attestation of Eligibility for an Election Period (Exh. 10a)	30.6, 60.1	N/A

⁷ Required unless combined acknowledgment/confirmation notice is issued.

⁸ Required unless combined acknowledgment/confirmation notice is issued.

Notice	Section(s)	Timeframe
Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11)	60.1	10 calendar days of receipt of request to disenroll
Request Information (Disenrollment) (Exh. 11a)	30, 60.1.2	10 calendar days of receipt of disenrollment request
Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)	60.1	N/A
Confirmation of Voluntary Disenrollment Identified Through DTRR (Exh. 12)	60.1, 60.3.2	10 calendar days of availability of DTRR
Denial of Disenrollment (Exh. 12a)	60.1.3	10 calendar days of receipt of disenrollment request
Rejection of Disenrollment (Exh. 12b)	60.1	10 calendar days of availability of DTRR
Confirmation of Disenrollment Due to Passive Enrollment into a Medicare- Medicaid Plan (Exh. 12c)	60.1	10 calendar days of availability of DTRR
Final Confirmation of Disenrollment Due to Out of Area > 6 Months (no exhibit)	60.2.1	N/A
Disenrollment Due to Death (Exh. 13)	60.2, 60.2.3, 60.1.2, 70.3.1	N/A
Disenrollment Due to Loss of Part A and/or Part B Coverage (Exh. 14)	50.2.2, 60.2, 60.1.2, 70.3.1	N/A
Notices on Terminations/Non-renewals	60.2.7	Follow requirements in 42 CFR 422.506 - 422.512
Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	60.3.2	N/A
Disenrollment for Disruptive Behavior (no exhibit)	60.3.2	Before the disenrollment transaction is submitted to CMS

Notice	Section(s)	Timeframe
Disenrollment for Fraud and Abuse (no exhibit)	60.3.3	Before the disenrollment transaction is submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	70.3, 70.3.1	10 calendar days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Part A/B Termination (Exh. 16)	70.3, 70.3.1	10 calendar days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error (Exh 17)	70.3, 70.3.1	10 calendar days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	70.3	10 calendar days after information was due to MA organization
Failure to Pay Plan Premiums - Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)	60.3.1	Within 15 calendar days of the premium due date
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	60.3.1	3 business days following the last day of the grace period
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	60.2.5, 60.3.1	N/A
Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount (Exh. 21a)	60.2.5	10 calendar days of notification on the DTRR
Failure to Pay Plan Premiums - Notice of Reduction in Coverage (Exh. 22)	60.3.1	10 calendar days of the expiration of the grace period
Notice of Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Plan Premium Amount Due for Reinstatement (Exh. 22a)	70.3.5	3 business days following the notification by CMS of favorable good cause determination

Notice	Section(s)	Timeframe
Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Premium Amount Due for Reinstatement (Exh 22b)	70.3.5	3 business days following favorable good cause determination
Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (Exh 22c)	70.3.5	3 business days following unfavorable good cause determination
Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment (Exh 22d)	70.3.5	10 calendar days of the expiration of the 3 month period
Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement) (Exh 22e)	70.3.5.1	3 business days following favorable good cause determination
Public Notices For Closing Enrollment due to Capacity Limit (Exh. 23)	50.10	15 days if related to CMS approved capacity limit
Notice that Enrollment request Placed on Waiting List (no exhibit)	50.10.1	10 calendar days of receiving enrollment request or of approval from CMS to limit enrollment
Re-affirming Intent to Not Enroll (no exhibit)	50.10.1	10 days of contacting member
Intent to Not Process Enrollment (no exhibit)	50.10.1	10 calendar days of learning beneficiary no longer wants to enroll
Medigap Rights per Special Election Period (Exh. 24)	60.1, 60.2	Upon request.
Request to cancel enrollment (Exh. 25)	70.2.1	10 calendar days of request
Confirmation of Reinstatement Per Notification From CMS (Exh. 25a)	70.2.1, 70.3, 70.3.1, 70.3.2 70.3.3	10 calendar days of DTRR confirming reinstatement

Notice	Section(s)	Timeframe
Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015) (Exh. 25b)	70.2.3	10 calendar days of DTRR confirming cancellation
Request to cancel disenrollment (Exh. 26)	70.2.1	10 calendar days of request
Inform Member of Auto-Enrollment (Exh. 27)	40.1.8	10 calendar days of identifying individual as needing auto-enrollment
Inform FBDE Member of Auto-Enrollment in PDP (Exh. 27a)	40.1.8	10 calendar days of identifying individual as needing auto-enrollment
Inform Member of Facilitated Enrollment (Exh. 28)	40.1.8	10 calendar days of identifying individual as needing facilitated enrollment
Inform Member of Facilitated Enrollment into PDP (Exh. 28a)	40.1.8	10 calendar days of identifying individual as needing facilitated enrollment
Request to Decline Part D (Exh. 29)	40.1.8	10 calendar days of request
Enrollment Status Update (Exh. 30)	N/A	10 calendar days of availability of DTRR
Model Employer/Union Group Enrollment Mechanism Notice (Exh. 31)	40.1.10	21 calendar days prior to effective date of enrollment
Loss of SNP Status (Exh. 32)	60.2.4	10 calendar days of loss of special needs status
Loss of SNP Status - Notification of Involuntary Disenrollment (Exh. 33)	60.2.4	3 business days of expiration of period of deemed continued eligibility
Research Potential Out of Area Status (Exh 34)	60.2.1.3	10 calendar days of receiving notice of change of address or indication of possible out-of-area residency

Disenrollment Due to Out of Area Status (No Response to Request for Address Verification) (Exh 35)	60.2.1.3	Within first 10 calendar days of the sixth month.
Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member) (Exh 36)	60.2.1.3	10 calendar days of receiving confirmation of out of area status
Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration (Exh. 37)	60.2, 60.2.1, 60.2.1.1	10 calendar days of notification on the DTRR
Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence (Exh. 38)	60.2, 60.2.1, 60.2.6	10 calendar days of notification on the DTRR

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

Referenced in section(s): 20, 20.6, 50, 50.9.1

All data elements with a “Yes” in the “Beneficiary response required on request” column are necessary in order for the enrollment election to be complete. For use of simplified enrollment mechanism, the plan must be able to obtain, from its internal data sharing, all the required elements that it does not include on the enrollment request. Elements required on the simplified enrollment mechanism, regardless of data sharing, are marked with an asterisk (*).

Data Element		CMS requires Field on enrollment mechanism?	Response required on request?	Exhibit # in which data element appears
1	MA Plan name ⁹	Yes*	Yes	1, 1b, 1c, 2, 3, 3a
2	Beneficiary name	Yes*	Yes	1, 1b, 1c, 2, 3, 3a
3	Beneficiary Date of Birth	Yes	Yes	1, 1b, 1c, 2
4	Beneficiary Sex	Yes	Yes	1, 1b, 1c, 2
5	Beneficiary Telephone Number	Yes*	No	1, 1b, 1c, 2, 3
6	Permanent Residence Address (with the exception of “County” – see below)	Yes	Yes	1, 1b, 1c, 2, 3
7	County (Optional Field)	No	No	1, 1b, 1c, 2, 3
8	Mailing Address	Yes	No	1, 1b, 1c, 2, 3
9	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No	No	1b, 1c, 2
10	E-mail Address (Optional Field)	No	No	1, 1b, 1c, 2, 3
11	Beneficiary Medicare number	Yes*	Yes	1, 1b, 1c, 2, 3
12	Additional Medicare information contained on Medicare card, or copy of card ¹⁰	No	No	1b, 1c, 2

⁹ If enrollment mechanism will be used for multiple plans, all plan names must be listed in a way that permits the applicant to clearly indicate their plan choice.

¹⁰ Plans may include the image of the Medicare card in enrollment mechanisms.

Data Element		CMS requires Field on enrollment mechanism?	Response required on request?	Exhibit # in which data element appears
13	Plan Premium Payment Option	Yes ¹¹	No ¹²	1, 1b, 1c, 3, 3a
14	Response to long term care question	No	No	1, 1b, 1c, 2
15	Response to other insurance COB information	Yes	Yes ¹³	1, 1b, 1c, 2
16	Beneficiary Ethnicity	Yes	No	1, 1b, 1c, 2, 3, 3a
17	Beneficiary Race	Yes	No	1, 1b, 1c, 2, 3, 3a
18	Beneficiary Gender Identity	Yes	No	1, 1b, 1c, 2, 3, 3a
19	Beneficiary Sexual Orientation	Yes	No	1, 1b, 1c, 2, 3, 3a
20	Option to request materials in language other than English (language preference) or in accessible formats	Yes*	No	1, 1b, 1c, 2, 3, 3a
21	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	No	No	2
22	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	No	No	2
23	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	No	No	2
24	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	No	No	1, 1b, 1c, 2, 3
25	Beneficiary signature and/or Authorized Representative Signature	Yes*	Yes ¹⁴	1, 1b, 1c, 2, 3, 3a
26	Date of signature	Yes*	No ¹⁵	1, 1b, 1c, 2, 3, 3a

¹¹ Zero premium MA-only plans omit this question

¹² Response defaults to direct bill if applicant fails to provide information

¹³ Refer to CMS COB guidance for additional information

¹⁴ For Employer/Union Group MA enrollment elections as described in § 40.1.10, and some other CMS approved enrollment elections, a signature is not required. For paper enrollment forms submitted without a signature, organization may verify with the applicant by telephone and document the contact instead of returning form.

¹⁵ As explained in § 50, the beneficiary and/or legal representative should write the date they signed the enrollment

Data Element		CMS requires Field on enrollment mechanism?	Response required on request?	Exhibit # in which data element appears
27	Authorized representative contact information	Yes*	Yes	1, 1b, 1c, 2,3, 3a
28	Employer or Union Name and Group Number	Yes	Yes	2
29	Question of which MA plan the beneficiary is currently a member of and to which MA plan the beneficiary is changing	Yes	Yes	3
30	For Special Needs Plans, description of SNP eligibility criteria	Yes	Yes	N/A
31	For MSA plans, all additional elements including proof that MSA bank account has been established	Yes	Yes	N/A
32	Information provided under “please read and sign below” All elements provided in model language must be included on enrollment request mechanisms. Option -- can be provided as narrative or listed as statements of understanding	Yes*	Yes	1, 1b, 1c, 2
33	Release of Information All elements provided in model language must be included on enrollment request mechanisms.	Yes*	Yes	1, 1b, 1c, 2
34	Notification of receiving plan materials electronically and ability to opt out	No	No	1, 1b, 1c, 2, 3, 3a
35	Question for individuals to indicate if they helped applicant with completing the form	Yes*	Yes	1, 1b, 1c, 2, 3, 3a

form; however, if they inadvertently fail 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 §40.1.10, the "signature date" is the date the employer's process was completed as recorded.

Data Element		CMS requires Field on enrollment mechanism?	Response required on request?	Exhibit # in which data element appears
36	Agent/Broker National Producer Number (NPN)	Yes*	Yes ¹⁶	1, 1b, 1c, 2, 3, 3a

¹⁶ Required for agents and brokers assisting the applicant with completing the enrollment form.

Appendix 3: Setting the Application Date on CMS Enrollment Transactions

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the beneficiary's choice of plan is honored. The application date is always a date prior to the effective date of enrollment. For use of simplified enrollment mechanism, follow the information based on how the enrollment request is received (e.g., paper, fax, telephone, electronically.)

Enrollment Request Mechanism	Application Date	Special Notes
Paper Enrollment Forms § 40.1.1	The date the paper request is initially received	Paper requests submitted to or collected by sales agents or brokers are considered received by the MA or Part D organization on the date the agent or broker receives the request from the individual
Fax § 40.1.1	The date the fax is received on the plan's fax machine	
Medicare.gov Online Enrollment Center (OEC) § 40.1.3	11 hours prior to the UTC generated date and time	
Electronic enrollment process § 40.1.2	The date the enrollee completes the request via the plan's electronic enrollment process	
Approved Telephonic Enrollment § 40.1.4	The date of the call	
Default Enrollment Option for Newly MA Eligible Medicaid Managed Care Plan Enrollees § 40.1.5	First day of individual's Initial Coverage Election Period (ICEP)	Effective date must always be the date of the individual's first entitlement to both Medicare Part A and Part B

Other Special Processes for Application Dates	Application Date	Special Notes
All enrollment requests into employer or union sponsored plans using the SEP EGHP, regardless of mechanism used	First day of the month prior to the effective date of enrollment	This applies to all mechanisms including §§ 40.1.10 and 40.1.10.1
Auto- and Facilitated Enrollment § 40.1.8	The first of the month prior to the effective date of the auto/facilitated enrollment. For Part D plans, the application date is set by CMS.	For cost plans conducting auto- and facilitated enrollment per § 50.1.1 of Chapter 17-D, set the application date to the first of the month prior to the effective date of the auto/facilitated enrollment.
SPAP enrollment requests as permitted in § 40.1.11 made during the AEP	October 15	The effective date of enrollment is the following January 1

Appendix 4: Examples of Good Cause Determinations

Referenced in section: **70.3.5**

This listing is to provide examples to assist plans in making favorable and unfavorable determinations for requests of reinstatement for good cause. For exact detail on the criteria and requirements for good cause reinstatements, see §70.3.5.

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

Favorable determination examples:

Example A: Ms. Grey was disenrolled on May 31, 2024 following a plan's two month grace period. She states that she has a caregiver who is responsible for making her premium payments to the plan. Ms. Grey attests that her caregiver caught pneumonia, was hospitalized for over 2 months from late March to late May 2024 and wasn't able to make payments. The plan issues a favorable good cause determination, since the member's caregiver was unexpectedly ill and hospitalized for a significant portion of the plan's grace period, which prevented the caregiver from making arrangements for timely payment. The plan's favorable determination is appropriate because: 1) The credible statement was provided about a serious illness and the person paying premiums was hospitalized for a significant portion of the plan's grace period; 2) The event (illness and hospitalization) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the caregiver could not have paid or made arrangements to pay the owed premiums within the plan's grace period as a result of the illness and hospitalization.

Example B: Mr. Lieber was disenrolled on April 30, 2024 following a plan's two month grace period. He states that he was in a car accident in mid-February, was hospitalized for one month and then sent to an assisted living facility for rehabilitation for one month. He indicated that he wasn't able to pay his bills during that time and didn't have any family to assist him. Because Mr. Lieber's situation was unexpected and he was hospitalized and institutionalized for a significant portion of the plan's grace period, the plan issues a favorable good cause determination. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about a serious illness and that the member was hospitalized and institutionalized for significant portion of the plan's grace period ; 2) The event (illness and hospitalization) was unexpected and out of the person's control; and 3) It is reasonable to conclude that Mr. Lieber could not have paid or made arrangements to pay the owed premiums within the plan's grace period as a result of the illness.

Example C: Ms. Kim was disenrolled on August 31, 2024 following the plan's two month grace period. She states that she was displaced from her apartment due to a

building fire in early June, was unable to access her belongings and as a result, was unable to make timely payment. The plan issues a favorable determination because Ms. Kim's home was significantly damaged by an unexpected and uncontrollable event during the plan's grace period. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about that the member's home was severely damaged due to an unexpected event; 2) The event (fire) was unexpected and out of the person's control; and 3) It is reasonable that the damage to Ms. Kim's home impaired her ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example D: Mr. Jones was disenrolled on June 30, 2024 following a plan's two month grace period. His son states that he found out that his father lost his coverage when he recently visited him. The son states that Mr. Jones was recently diagnosed with dementia and his condition is quickly worsening, which caused him to not pay his premiums. The son states that because of his father's condition, he is taking over financial matters for his father and will pay the arrearages. The plan issues a favorable determination because Mr. Jones was newly diagnosed with a serious illness that directly impacts his ability to pay his premiums. The plan's favorable determination is appropriate because: 1) The creditable statement was provided about a serious and prolonged illness with rapid deterioration, that directly impacted the member's ability to pay premiums timely; 2) The event (serious illness with rapid deterioration) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the onset of dementia caused Mr. Jones to fail to make the timely payment during the grace period.

Example E: Ms. Brown was disenrolled on July 31, 2024 following the plan's three-month grace period. She states that for the past four months, her husband was receiving intensive treatment for cancer and she was taking care of him during this time. During this time, she fell behind in paying bills due to the care he needed. The plan issues a favorable determination because Ms. Brown's husband was seriously ill for a prolonged period time during the plan's grace period. The plan's favorable determination is appropriate because: 1) The credible statement was provided about a serious and prolonged illness of an immediate family member; 2) The event (serious and prolonged illness) was unexpected and out of the person's control; and 3) It is reasonable to conclude that Ms. Brown's circumstance in providing caregiver services for her spouse impacted her ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example F: Mrs. Duke was disenrolled on August 31, 2024 following the plan's two month grace period. She states that her husband had been handling her bills and making payments timely. However, he passed away in July 2024, leaving her with no caregiver or family member to take over the responsibility. The plan issues a favorable good cause determination because of the recent death of Mrs. Duke's husband, which was unexpected and out of her control. The plan also offers Mrs. Duke the option to set up electronic payments and premium withholding to help

ensure that she remains current in paying her premiums. The plan's favorable determination is appropriate because: 1) The credible statement was provided about the recent death of a spouse; 2) The event (death of spouse) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the unexpected death impacted Mrs. Duke's ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Example G: Mr. Santiago lives in Lucas County, Iowa, and was disenrolled on July 31, 2024 following the plan's two month grace period. He states that there were severe storms and significant flooding in his town and the Post Office closed for a week during the grace period while the flooding receded. The plan checks the FEMA.gov website and verifies that Lucas County, Iowa, was declared as a federal disaster area. The plan issues a favorable good cause determination because the declared federal state of emergency occurred during the plan's grace period and that emergency impacted Mr. Santiago's ability to pay his premiums timely. The plan's favorable determination is appropriate because: 1) The credible statement provided was an extreme weather-related event The event (declared state of emergency) was unexpected and out of the person's control; 2) The event was unexpected and out of the person's control; and 3) It is reasonable to conclude that this circumstance impacted Mr. Santiago's ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

Unfavorable determination examples:

Example A: Mr. Smith was disenrolled on June 30, 2024 following the plan's three month grace period. He states that he was unable to pay his plan premiums because he was in the hospital for a week in May for a planned surgical procedure, followed by a two week stay in a rehabilitation facility. The plan issues an unfavorable good cause determination because Mr. Smith was not unexpectedly hospitalized or institutionalized for a significant portion of the plan's grace period. Even though Mr. Smith was away from his home undergoing medical treatment for three weeks, he had a reasonable opportunity and ability to resolve the delinquency within the plan's grace period. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which hospitalization or institutionalization occurred for a significant portion of the plan's grace period; 2) The situation (planned hospital procedure) was not unexpected, nor did it render the individual without control over timely payment of his premiums; and 3) It is reasonable to expect that Mr. Smith could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Smith may not be reinstated for good cause.

Example B: Mr. Jones was disenrolled on May 31, 2024 following the plan's two month grace period. He states that he was unable to pay his plan premiums because he has End-Stage Renal Disease (ESRD) and goes to a facility for dialysis three times a week. Mr. Jones states that he sometimes has difficulty keeping track of his

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

Example C: Ms. Ferrera was disenrolled on March 31, 2024 following the plan's two month grace period. She states that she and her family were away from home on an extended vacation and she wasn't aware that she had been disenrolled until they returned home. Ms. Ferrera states that she is willing and able to pay the plan premiums that were not paid and added that she needs her coverage due to her many medications for diabetes. The plan issues an unfavorable good cause determination because Ms. Ferrera did not have a circumstance that was unexpected or unforeseen in any way. While she has a chronic illness and requires medicines to treat her condition, Ms. Ferrera had the ability to make arrangements to have the premiums paid on time while she was out of town. The plan's unfavorable determination is appropriate because: 1) The credible statement provided of being away from home on vacation is listed specifically as the basis for an unfavorable determination; 2) The situation (planned vacation) was not unexpected in any way; and 3) It is reasonable to expect that Ms. Ferrera could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Ferrera may not be reinstated for good cause.

Example D: Mr. Davis was disenrolled on July 31, 2024 following the plan's two-month grace period. He states that earlier in the year he moved a short distance from his previous residence but did not inform the plan of his new address. The plan issues an unfavorable good cause determination because the plan materials clearly state that it is the enrollee's responsibility to inform the plan of a change of address. This is not a case of plan error, since the plan sent the monthly billing statements and the disenrollment notice to the address most recently provided by Mr. Davis. (See §70.3.4 for information on reinstatement following disenrollment due to plan error.) The plan's unfavorable determination is appropriate because: 1) The credible statement provided of an unreported change of address is listed specifically as the basis for an unfavorable determination; 2) The situation (permanent residence change) was not unexpected in any way; and 3) It is reasonable to expect Mr. Davis to inform the plan of his new address, to avoid any delay in his receipt of important materials, such as monthly billing statements and notices regarding his enrollment status. Mr. Davis

may not be reinstated for good cause.

Example E: Ms. Adams was disenrolled on April 30, 2024 following the plan's three month grace period. She states that the basement in her home and her electricity were affected by recent flooding and that this prevented her from sending her monthly plan premium payments. Local road closures and power outages lasted for up to a week for some residents. The plan issues an unfavorable good cause determination because the local storms and subsequent flooding did not severely damage Ms. Adams home or prevent her from making the premium payments; further, there was neither a state nor federal disaster declaration. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which the home was severely damaged nor was there a federal or state declaration of emergency; and 2) While road closures and power outages impacted some area residents, it isn't clear that Ms. Adams was directly impacted by these events or was impeded from being able to make timely payment; and 2) It is reasonable to expect that Ms. Adams could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Adams may not be reinstated for good cause.

Example F: Mrs. Johnson was disenrolled on March 31, 2024 following the plan's two month grace period. She states that her husband is responsible for making her premium payments to the plan. Mrs. Johnson attests that her husband became ill, was hospitalized for two weeks in February 2024 and was not able to make payments. The plan issues an unfavorable good cause determination since, although her husband's illness was unexpected, he was not hospitalized for a significant portion of the plan's grace period, which would have caused him to be unable to make the payment in a timely manner. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not that hospitalization or institutionalization occurred for a significant portion of the plan's grace period; and 2) It is reasonable to expect that Mr. Johnson could have paid or made arrangements to pay the owed amounts for this wife's coverage within the plan's grace period. Mrs. Johnson may not be reinstated for good cause.

Example G: Mr. Patel was disenrolled on September 30, 2024 following the plan's three month grace period. He states that his income decreased and he was unable to afford to pay his premiums. The plan issues an unfavorable good cause determination because there wasn't an unexpected or unforeseen circumstance that prevented payment from being made by Mr. Patel in a timely manner. The plan's unfavorable determination is appropriate because: 1) The credible statement provided of personal financial issues is listed specifically as the basis for an unfavorable determination; and 2) It is reasonable to expect that Mr. Patel could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Patel may not be reinstated for good cause.

Example H: Ms. Ulman was disenrolled on June 30, 2024 following the plan's two month grace period. She states that she needs to refill her medications and that she

paid her owed amounts to the plan on July 20, 2024, following her disenrollment effective date. The plan issues an unfavorable good cause determination because Ms. Ulman's need for medications did not inhibit her ability to pay her premiums timely. The plan's unfavorable determination is appropriate because: 1) The situation (medication needs) was not unexpected or out of the person's control, nor did it impede her ability to pay timely; and 2) It is reasonable to expect that Ms. Ulman could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Ulman may not be reinstated for good cause.

Example I: Ms. Taylor was disenrolled on March 31, 2024 following a plan's three-month grace period. She states that when she enrolled in the plan during the fall open enrollment period, she selected premium withhold as the method of premium payment. She says that she received a premium bill from the new plan for January and, in addition, received a delinquency notice in early January warning of disenrollment at the end of March if she did not pay the premium for January. She stated that she ignored the bill and the delinquency notice, assuming that her plan premiums were being withheld from her Social Security benefit check starting with the January premium. The plan issues an unfavorable good cause determination because the plan explained in its letter to Ms. Taylor following submission of the enrollment transaction and receipt of the DTRR that her first month's plan premium was not withheld, that she was responsible for paying her premiums until premium withholding started and that she could be involuntarily disenrolled. The plan concluded that Ms. Taylor had been appropriately advised of her obligation to pay the bill for the January premium and that this was reiterated by means of the subsequent premium bills and the delinquency letter the plan sent to her in January. The plan's unfavorable determination is appropriate because: 1) The situation (misunderstanding of ramifications of nonpayment of premiums) was not unexpected in any way; 2) The situation did not impede her ability to pay timely; and 3) It is reasonable to expect that Ms. Taylor could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Taylor may not be reinstated for good cause.

Exhibits

Model Medicare Advantage Enrollment Forms & Notices

This section contains model exhibits for plan issued notices to beneficiaries regarding enrollment matters. MA organizations may make the following modifications to CMS model materials and still submit the material to CMS under the ten (10) day review period: populating variable fields, correcting grammatical errors, changing the font (within standards described in the CMS marketing guidelines), adding the plan name/logo, and adding the CMS marketing material identification number.

For more information on CMS marketing and mailing requirements as well as the instructions for submitting model documents for review, see the CMS Medicare Communication and Marketing Guidelines.

Exhibit 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C)

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Send your completed and signed form to:

<Plan Name>
<Plan address>
<Plan address>
<Plan address>

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call <Plan Name> at <phone number>. TTY users can call < phone number >.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a <Plan Name> al <phone number/TTY> o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

☐ Product ABC – \$XX per month

☐ Product XYZ – \$XX per month

FIRST name:

LAST name:

[Optional: Middle Initial]:

Birth date: (MM/DD/YYYY)

(/ /)

Sex:

☐ Male ☐ Female

Phone number:

()

Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

[Optional: County]:

State:

ZIP Code:

Mailing address, if different from your permanent address (PO Box allowed):

Street address:

City:

State:

ZIP Code:

Your Medicare information:

Medicare Number:

____ - ____ - ____

Answer these important questions:

[MA-PDs insert:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to <Plan>? ☐ Yes ☐ No

Name of other coverage:

Member number for this coverage:

Group number for this coverage

[Special Needs Plans] insert question(s) regarding the required special needs criteria]

IMPORTANT: Read and sign below:

- [MA plans insert: I must keep both Hospital (Part A) and Medical (Part B) to stay in <Plan Name>.]
- By joining this Medicare Advantage, I acknowledge that <Plan Name> will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- [MA plans insert: I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services provided by <Plan Name> and contained in my <Plan Name> “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <Plan Name> will pay for benefits or services that are not covered.]
- 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 legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature:

Today's date:

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number:

Relationship to enrollee:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- | | |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | |
| <input type="checkbox"/> I choose not to answer. | |

What's your race? Select all that apply.

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American |
| Asian: | Native Hawaiian and Pacific Islander: |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Korean | <input type="checkbox"/> White |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> I choose not to answer. |
| <input type="checkbox"/> Other Asian | |

What is your gender? Select one.

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Woman | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Man | <input type="checkbox"/> I choose not to answer |
| <input type="checkbox"/> Non-binary | |

Which of the following best represents how you think of yourself? Select one.

- | | |
|--|--|
| <input type="checkbox"/> Lesbian or gay | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> I choose not to answer |

Select one if you want us to send you information in a language other than English.

[☐ Plans insert the languages required in your service area.]

Select one if you want us to send you information in an accessible format.

- ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact <plan name> at <phone number> if you need information in an accessible format other than what's listed above. Our office hours are <insert days and hours of operation>. TTY users can call <TTY number>.

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

I want to get the following materials via email. Select one or more.

☐ *[Plans may list those types or categories of materials that are available for electronic delivery]*

E-mail address:

Paying your plan premiums

[Plans with premiums insert: You can pay your monthly plan premium [MA-PD plans with premiums insert: (including any late enrollment penalty that you currently have or may owe)] by mail <insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”> each month <insert optional intervals, if applicable, for example “or quarterly”>. You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.]

[MA-PDs with premiums insert: If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON’T pay [insert appropriate plan and/or organization name] the Part D-IRMAA.]

For individuals helping enrollee with completing this form only

Complete this section if you’re an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____
Signature: _____ National Producer Number (Agents/Brokers only): _____

[optional space for other administrative information needed by plan]

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Exhibit 1a: Information to include on or with Enrollment Mechanism – Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.

- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

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

Exhibit 1b: Model MA MSA Plan Enrollment Request Form (“Election” may also be used)

Please contact <plan name> if you need information in another language or format (i.e. Braille).

To Enroll in <plan name>, Please Provide the Following Information:			
[Required if form used for multiple plans: Please check which plan you want to enroll in: ____ Product ABC \$XX per month ____ Product XYZ \$XX per month]			
LAST name:		FIRST Name:	Middle Initial:
Birth Date: (__ __/__/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	[Optional field: Alternate Phone Number: ()]
Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address..):			
City:	[Optional field: County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:		City:	State: Zip Code:
[Optional field: Emergency contact: _____]			
Phone Number: _____ Relationship to You: _____]			
[Optional field: E-mail Address: _____]			

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See “What happens next?” on this page to send your completed form to the plan.

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number: _____

Is Entitled to: _____ Effective Date: _____

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions

1. To enroll in <MSA plan name>, you may not have other health coverage as described below. Please answer each of the following questions:

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

B. Are you receiving Medicare Hospice benefits? ☐ Yes ☐ No

C. Some individuals may have other health coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or other health benefits that cover all or part of the annual Medicare MSA deductible. If you have any other such coverage, you aren't eligible to enroll in <MSA plan name>

Will you have other health coverage in addition to <MSA plan name>? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage so we can decide if you are eligible to enroll in <MSA plan name>:

Name of other coverage: _____

ID # for this coverage: _____

Group # for this coverage: _____

2. Will you reside in the United States for at least 183 days during each year you are enrolled in <MSA plan>? ☐ Yes ☐ No

3. Do you or your spouse work? ☐ Yes ☐ No

The fields in this section are optional	
<u>Answering these questions is your choice. You can't be denied coverage because you don't fill them out.</u>	
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.	
<input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin	<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a
<input type="checkbox"/> Yes, Puerto Rican	<input type="checkbox"/> Yes, Cuban
<input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin	
<input type="checkbox"/> I choose not to answer.	
What's your race? Select all that apply.	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American
Asian:	Native Hawaiian and Pacific Islander:
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Chinese	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan
<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Korean	<input type="checkbox"/> White
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> I choose not to answer.
<input type="checkbox"/> Other Asian	
What is your gender? Select one.	
<input type="checkbox"/> Woman	<input type="checkbox"/> I use a different term: _____
<input type="checkbox"/> Man	<input type="checkbox"/> I choose not to answer
<input type="checkbox"/> Non-binary	
Which of the following best represents how you think of yourself? Select one.	
<input type="checkbox"/> Lesbian or gay	<input type="checkbox"/> I use a different term: _____
<input type="checkbox"/> Straight, that is, not gay or lesbian	<input type="checkbox"/> I don't know
<input type="checkbox"/> Bisexual	<input type="checkbox"/> I choose not to answer
Please check one of the boxes below if you would prefer that we send you information in a language other than English or an accessible format: <input type="checkbox"/> <include list of available languages> <input type="checkbox"/> <include list of accessible formats (like Braille, audio CD, data CD, or large print> Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.	
<i>[Optional field: If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]</i>	
Please Read and Sign Below:	
<MSA Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any health coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage,	

or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan ("disenroll") during the Annual Enrollment Period that is October 15th through December 7th of every year (effective the following January 1st) or under certain limited special circumstances, by sending a request in writing to <MSA plan name>. If I choose a Medicare MSA plan and haven't before joined an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan isn't complete until the bank account is established. I understand that I am enrolling in a plan that doesn't pay for Medicare covered services until a high deductible is met, but <plan name> allows me to use funds in my MSA account to pay for health services. Withdrawals made from the MSA bank account aren't taxed when used for IRS-qualified medical expenses. I would owe income tax and up to a 50% penalty for withdrawals used for non-medical expenses. After the deductible is met the plan pays 100% of Medicare-covered services.

[MSA Demonstration Plans insert: If I am enrolling in a MSA demonstration plan, I may be responsible for cost sharing for certain preventive services, as described by the plan, before the deductible is met. After the deductible is met, I may be responsible for cost-sharing until my expenses for covered services reach the out-of-pocket maximum, after which the MSA demonstration plan pays 100% of Medicare covered services.]

If I have any questions regarding the initial set-up of my MSA bank account or any of the information in this enrollment form, I should contact the <plan name> at <contact number>.

<MSA plan name> serves a specific service area. If I move out of the area that <MSA Plan 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 <MSA plan 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 <MSA plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

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

I understand that if I disenroll before the end of the plan year (December 31st), <plan name> may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months left in the year after the disenrollment date. I understand that, if I die, my estate will be responsible for any money owed to Medicare. My estate keeps any amount over what is owed to Medicare.

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. I also acknowledge that <MSA plan name> will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this

signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:

Today's Date:

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

Name: _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee _____

Keeping records -- As an authorized representative, it is important that you keep records of when funds in the MSA account are used, as well as how the funds are used.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

[optional space for other administrative information needed by plan]

Exhibit 1c: Model PFFS Individual Enrollment Request Form (“Election” may also be used)

Please contact <plan name> if you need information in another language or format (Braille).

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

[Required if form used for multiple plans: Please check which plan you want to enroll in:

____ Product ABC \$XX per month ____ Product XYZ \$XX per month]

LAST name: FIRST Name: Middle Initial

Birth Date:
(__ __/__/__ __ __ __)
(M M / D D / Y Y Y Y)

Sex:
☐ M ☐ F

Home Phone
Number: ()

[Optional
field: Alternate
Phone
Number:]

Permanent Residence Street Address (Don’t enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City: [Optional field: County:] State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ZIP Code:

[Optional field: **Emergency contact:** _____]

Phone Number: _____ **Relationship to You:** _____]

[Optional field: **E-mail Address:** _____]

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number: _____

Is Entitled to: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

[Zero premium MA-only plans omit this section:

Paying Your Plan Premium

Zero premium MA-PD plans insert: **If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail <insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”> each month <insert optional intervals, if applicable, for example “or quarterly”>. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board. DO NOT pay [insert appropriate plan and/or organization name] the Part D-IRMAA.]**

[MA-only and MA-PD plans with premiums insert: **You can pay your monthly plan premium [MA- PD plans with premium insert: (including any late enrollment penalty you have or may owe)] by mail <insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”> each month <insert optional intervals, if applicable, for example “or quarterly”>. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.**

[MA-PD plans with premiums insert: If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board. DO NOT pay [insert appropriate plan and/or organization name] the Part D-IRMAA.]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month <optional language in place of “bill each month”: “coupon book” or “payment book”>.

Please select a premium payment option:

☐ Get a bill <option: “coupon”, “payment” book, etc>
<option to include other billing intervals e.g. bi-monthly, quarterly>

[Optional - Include other payment methods, such as EFT & credit card as follows:

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number: _____

Expiration Date: __/__/__(MM/YYYY) __

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

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

Please read and answer these important questions:

[*PFFS-PD plans insert:*

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <PFFS 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: _____]

2. Do you or your spouse work? ☐ Yes ☐ No

[*Optional field: Please tell us the name of your Primary Care Physician (PCP):*

Doctor’s Name: _____ Phone Number: _____]

[*Optional field: Please tell us the name of your preferred hospital, clinic or health center:*

Name: _____ City: _____ State: _____]

The fields in this section are optional

Answering these questions is your choice. You can’t be denied coverage because you don’t fill them out.

<p>Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> I choose not to answer. </div> <div> <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a <input type="checkbox"/> Yes, Cuban </div> </div>	
<p>What's your race? Select all that apply.</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> American Indian or Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian </div> <div> <input type="checkbox"/> Black or African American Native Hawaiian and Pacific Islander: <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I choose not to answer. </div> </div>	
<p>What is your gender? Select one.</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Non-binary </div> <div> <input type="checkbox"/> I use a different term: _____ <input type="checkbox"/> I choose not to answer </div> </div>	
<p>Which of the following best represents how you think of yourself? Select one.</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Straight, that is, not gay or lesbian <input type="checkbox"/> Bisexual </div> <div> <input type="checkbox"/> I use a different term: _____ <input type="checkbox"/> I don't know <input type="checkbox"/> I choose not to answer </div> </div>	
<p>Please check one of the boxes below if you would prefer that we send you information in a language other than English or an accessible format:</p> <p>____ <include list of available languages></p> <p>____ <include list of accessible formats (like Braille, audio CD, data CD, or large print></p> <p>Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.</p>	
<p>[<i>Optional field:</i> If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]</p>	



Please Read This Important Information

[All PFFS plans insert: <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[All PFFS plans insert, except for cases in which beneficiary is switching from one PFFS plan to another PFFS plan offered by the same MAO: Once <plan name> has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee- for-Service plan works and to confirm your intent to enroll in <plan name>. If <plan name> isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.]

[PFFS-PD plans insert: If you currently have health coverage from an employer or union, joining <PFFS-PD Name> could affect your employer or union health benefits. If you have health coverage from an employer or union, joining <PFFS-PD Name> may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there 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:

<Plan Name> is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan [PFFS w/PD insert "or Medicare prescription drug plan."]. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [PFFS w/o PD only plans insert: "I understand that since this plan does not offer Medicare prescription drug coverage, I may get coverage from another Medicare prescription drug plan. If I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future."] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7 of every year), or under certain special circumstances.

As a Medicare Private Fee-For-Service plan, <plan name> works differently than a Medicare supplement plan as well as other Medicare Advantage plans. <Plan name> pays instead of Medicare, and I will be responsible for the amounts that <plan name> doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in <plan name>.

Before seeing a provider, I should verify that the provider will accept <plan name>. I understand that my health care providers have the right to choose whether to accept <plan name>'s payment

terms and conditions every time I see them. I understand that if my provider doesn't accept <plan name>, I will need to find another provider that will.

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify <plan name> so I can disenroll and find a new plan in my new area. Once I am a member of <plan 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 <plan name> when I get it to know which rules I must follow in to get coverage with this Private Fee-For-Service plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

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

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. I also acknowledge that <plan name> will release my information [**PFFS-PD plans insert:** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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

Signature:	Today's Date:
-------------------	----------------------

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

Name: _____

Address: _____

Phone Number: (____) ____ - _____

Relationship to Enrollee: _____

For individuals helping enrollee with completing this form only	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.	
Name: _____	Relationship to enrollee: _____
Signature: _____	National Producer Number (Agents/Brokers only): _____
[optional space for other administrative information needed by plan]	

Exhibit 1d: Model Simplified Enrollment Form

[MA Organizations must collect all required data as outlined in Appendix 2. Additional data elements must be added for any required data not already available.]

You are requesting enrollment into a Medicare Advantage Plan offered by <name of MA Organization>. You agree to allow <name of MA Organization> to use your personal information we have on file from your current enrollment in <our non-Medicare coverage [or optionally: name non-Medicare plan]> to complete your enrollment request.

Tell Us About Yourself:		
LAST Name:	FIRST Name:	Middle Initial:
Your current <non-Medicare plan name> health plan member number:	Your Medicare Number:	(Optional) Part A coverage starts: Part B coverage starts:
Your Telephone Number (in case we need to reach you):		
Tell Us Which Plan You Want to Enroll: <i>[Include plan names and premiums. If using form for multiple plans, display options for beneficiary to clearly indicate plan choice.]</i>		
_____ Plan A \$XX per month _____ Plan B \$XX per month		
[If offering a zero premium plan or reduction of the Part B premium, may delete or modify the references to plan and Medicare premiums:] I understand that this plan may have a different provider network and that I must pay the monthly plan premium in addition to any Medicare Part A and Part B premiums I may owe.		
<i>[May include options for premium payment. If not offering options for premium payment, include: You will get a bill from <plan name> for your monthly premium. Contact <plan name> if you want to pay your premium by <payment options offered by the plan>.]</i>		
<i>[Add any other items not available via internal data sharing to collect the remainder of required information]</i>		
<u>Answering these questions is your choice. You can't be denied coverage because you don't fill them out.</u>		
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.		
<input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin	<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a	
<input type="checkbox"/> Yes, Puerto Rican	<input type="checkbox"/> Yes, Cuban	
<input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin		
<input type="checkbox"/> I choose not to answer.		

What's your race? Select all that apply.

☐ American Indian or Alaska Native

Asian:

☐ Asian Indian

☐ Chinese

☐ Filipino

☐ Japanese

☐ Korean

☐ Vietnamese

☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:

☐ Guamanian or Chamorro

☐ Native Hawaiian

☐ Samoan

☐ Other Pacific Islander

☐ White

☐ **I choose not to answer.**

What is your gender? Select one.

☐ Woman

☐ Man

☐ Non-binary

☐ I use a different term: _____

☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay

☐ Straight, that is, not gay or lesbian

☐ Bisexual

☐ I use a different term: _____

☐ I don't know

☐ **I choose not to answer**

You are requesting enrollment into a Medicare Advantage Plan offered by <name of MA Organization>. You agree to allow <name of MA Organization> to use your personal information we have on file from your current enrollment in <our non-Medicare coverage [or optionally: name non-Medicare plan]> to complete your enrollment request.

IMPORTANT: Read and Sign Below:

- <Plan name> is a Medicare Advantage prescription drug plan and has a contract with the Federal government. I must continue to keep both Part A and Part B to stay enrolled in <plan name>.
- I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with <plan name>, he/she may be compensated based on my enrollment in <plan name>.
- **Release of Information:** By joining this Medicare Advantage Prescription Drug Plan, I acknowledge that the plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my <plan name> coverage begins, I must get all of my medical and prescription drug benefits from <plan name>. Benefits and services authorized by <plan name> and contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. **Without authorization, neither Medicare nor <plan name> will pay for benefits or services.**
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature:	Date:
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Address:
Phone Number:	Relationship to Enrollee:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____
 Signature: _____ National Producer Number (Agents/Brokers only): _____

[optional space for other administrative information needed by plan]

Exhibit 2: Model Employer/Union Group Health Plan Enrollment Request Form ("Election" may also be used)

Please contact <plan name> if you need information in another language or format (Braille).

To Enroll in <plan name>, Please Provide the following Information:			
Employer or Union Name:		Group #:	
[Required if form used for multiple plans: Please check which plan you want to enroll in: _____ Product ABC \$XX per month _____ Product XYZ \$XX per month]			
LAST name:		FIRST Name:	Middle Initial
Birth Date: (__ / __ / __ __ __ __) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	[Optional field: Alternate Phone Number:]
Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):			
City:	[Optional field: County:]	State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:		City:	State: ZIP Code:
[Optional field: E-mail Address: _____]			
Please Provide Your Medicare Insurance Information			
Please take out your red, white and blue Medicare card to complete this section. <ul style="list-style-type: none"> Fill out this information as it appears on your Medicare card. - OR - Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. 		Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a Medicare Advantage plan.	
Please read and answer these important questions			

1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, retirement date (month/date/year): _____ If no, name of retiree: _____	
2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ Name(s) of dependent(s): _____	
3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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 <u>prescription</u> drug coverage in addition to <plan name>? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please list your other coverage and your identification (ID) number(s) for this coverage: <div style="display: flex; justify-content: space-between;"> Name of other coverage: ID # for Coverage: </div>	
5. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" please provide the following information: Name of Institution: _____ Address & Phone Number of Institution (number and street): _____	
[Optional field: Please Choose a Primary Care Physician (PCP), clinic or health center:]	
<u>The fields in this section are optional</u>	
<u>Answering these questions is your choice. You can't be denied coverage because you don't fill them out.</u>	
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply. <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin <input type="checkbox"/> I choose not to answer. </div> <div style="width: 50%;"> <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a <input type="checkbox"/> Yes, Cuban </div> </div>	
What's your race? Select all that apply. <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> American Indian or Alaska Native Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian </div> <div style="width: 50%;"> <input type="checkbox"/> Black or African American Native Hawaiian and Pacific Islander: <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> I choose not to answer. </div> </div>	
What is your gender? Select one. <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Woman <input type="checkbox"/> Man </div> <div> <input type="checkbox"/> I use a different term: _____ <input type="checkbox"/> I choose not to answer </div> </div>	

<input type="checkbox"/> Non-binary	
Which of the following best represents how you think of yourself? Select one.	
<input type="checkbox"/> Lesbian or gay	<input type="checkbox"/> I use a different term: _____
<input type="checkbox"/> Straight, that is, not gay or lesbian	<input type="checkbox"/> I don't know
<input type="checkbox"/> Bisexual	<input type="checkbox"/> I choose not to answer
Please check one of the boxes below if you would prefer that we send you information in a language other than English or an accessible format:	
_____ <include list of available languages>	
_____ <include list of accessible formats (like Braille, audio CD, data CD, or large print>	
Please contact <plan name> at <phone number> if you need information in an accessible format or language other than what is listed above. Our office hours are <insert days and hours of operation>. TTY users should call <TTY number>.	
[Optional field: If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]	
Please Read and Sign Below	
<u>By completing this enrollment application, I agree to the following:</u>	
<p><Plan Name> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [MA-only plans insert: I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.</p> <p><Plan Name> serves a specific service area. If I move out of the area that <Plan 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 <Plan 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 <plan name> when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.</p> <p>[MA PFFS do not include the following paragraph: I understand that beginning on the date <plan name> coverage begins, I must get all of my health care from <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.]</p> <p>I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or</p>	

contracted with <plan name>, he/she may be paid based on my enrollment in <plan name>.

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. I also acknowledge that <plan name> will release my information [**MA-PD plans insert:** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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

Signature:

Today's Date:

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

Name: _____

Address: _____ Phone Number: (____) _____ - _____

Relationship to Enrollee _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

[optional space for other administrative information needed by plan]

Exhibit 3: Model Short Enrollment Request 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 offered by the same parent organization. This form is not applicable to MSA.

Name of Plan You are Enrolling In: _____			
Name: _____		Medicare Number: _____ (Note: may use “member number” instead of “Medicare Number”)	
Home Phone Number: _____			
Permanent Street Address (Don’t enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)			
City: _____	<i>[Optional field: County:]</i> _____	State: _____	ZIP Code: _____
Mailing Address (only if different from your Permanent Street Address):			
Street Address: _____		City: _____	State: _____ ZIP Code: _____
Please fill out the following:			
I am currently a member of the _____ plan in _____ <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 \$_____.			
<i>[Optional Field: Name of chosen Primary Care Physician (PCP), clinic or health center:]</i>			
The fields in this section are optional			
<u>Answering these questions is your choice. You can’t be denied coverage because you don’t fill them out.</u>			
Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.			
<input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin		<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a	
<input type="checkbox"/> Yes, Puerto Rican		<input type="checkbox"/> Yes, Cuban	
<input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin			
<input type="checkbox"/> I choose not to answer.			

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren’t about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See “What happens next?” on this page to send your completed form to the plan.

What's your race? Select all that apply.

☐ American Indian or Alaska Native

Asian:

☐ Asian Indian

☐ Chinese

☐ Filipino

☐ Japanese

☐ Korean

☐ Vietnamese

☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:

☐ Guamanian or Chamorro

☐ Native Hawaiian

☐ Samoan

☐ Other Pacific Islander

☐ White

☐ **I choose not to answer.**

What is your gender? Select one.

☐ Woman

☐ Man

☐ Non-binary

☐ I use a different term: _____

☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay

☐ Straight, that is, not gay or lesbian

☐ Bisexual

☐ I use a different term: _____

☐ I don't know

☐ **I choose not to answer**

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

_____ <include list of available languages>

_____ <include list of accessible formats (like Braille, audio CD, data CD, or large print)>

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

[*Optional field:* If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]

[Zero premium MA-only plans omit this section]

Your Plan Premium

[Zero premium MA-PD plans insert: **If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail** <insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”> each month <insert optional intervals, if applicable, for example “or quarterly”>. **You can also pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. Do NOT pay** [insert appropriate plan and/or organization name] **the Part D-IRMAA.**]

[MA-only and MA-PD plans with premiums insert: **You can pay your monthly plan premium [MA-PD plans with premium insert: (including any late enrollment penalty you have or may owe)] by mail** <insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”> each month <insert optional intervals, if applicable, for example “or quarterly”>. **You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.**

[MA-PD plans with premiums also insert: **If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay [insert appropriate plan and/or organization name] the Part D-IRMAA.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won’t have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don’t even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn’t cover.

If you don’t select a payment option, you will get a bill each month <optional language in place of “bill each month”: “coupon book” or “payment book”>.

Please select a premium payment option:

- ☐ Get a bill <option: Include other optional methods, such as EFT & credit card>
- ☐ Automatic deduction from your monthly Social Security or RRB benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

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



Please Read This Important Information

[Insert if enrolling in a PFFS plan: <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. Your doctor or hospital isn't required to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[Insert if enrolling in a PFFS plan, except for cases in which the member is switching from one PFFS plan to another PFFS plan offered by the same parent organization: Once <plan name> has your enrollment form, a plan representative will call you. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in <plan name>. If <plan name> isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.]

Please Read and Sign Below:

<Plan> is a plan that has a contract with the Federal government.

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

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. I also acknowledge that <plan name> will release my information [**MA-PD plans insert:** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

[**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 <plan name>, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**

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

Signature:	Today's Date:
<p>If you are the authorized representative, you must sign above and provide the following information:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone Number: (____) ____ - ____</p> <p>Relationship to Enrollee _____</p>	

For individuals helping enrollee with completing this form only
<p>Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.</p> <p>Name: _____ Relationship to enrollee: _____</p> <p>Signature: _____ National Producer Number (Agents/Brokers only): _____</p> <p><i>[optional space for other administrative information needed by plan]</i></p>

Exhibit 3a: Model Plan Selection Form for MA-PD - Switch From Plan to Plan Within Parent Organization

This form is not applicable to MSA.

Dear <plan name> Member:

<Introduction - In the introduction of cover letter, MA organization may include language regarding plan choices, description of plans, differences, etc.>. [Insert to describe PFFS plans:

<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

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

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.]

If you select another plan and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will be <premium amount> and you may continue to see any <current plan name> 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 <plan name> at <phone number - if plan is planning to have informational meetings - include information about time/place of meetings >. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Plan Selection Form

Date:

Member Name:

Member Number:

I want to transfer from my current 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>
<monthly premium amount>
<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>
<monthly premium amount>
<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.>

[Insert to describe PFFS plans: <Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[Zero premium MA-only plans omit this section:

Your Plan Premium

[Zero premium MA-PD plans insert: If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how would prefer to pay it. You can pay by mail <insert optional methods: "Electronic Funds Transfer (EFT)", "credit card"> each month <insert optional intervals, if applicable, for example "or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.]

***[MA-only and MA-PD plans with premiums insert: You can pay your monthly plan premium
[MA-PD plans with premium insert: (including any late enrollment penalty you have or may***

owe)] by mail *<insert optional methods: “Electronic Funds Transfer (EFT)”, “credit card”>*
each month *<insert optional intervals, if applicable, for example “or quarterly”>*. You can also
choose to pay your premium by automatic deduction from your Social Security or Railroad
Retirement Board Check each month.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don’t even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don’t select a payment option, you will receive a bill each month *<optional language in place of “bill each month”: “coupon book” or “payment book”>*.

Please select a premium payment option:

Receive a bill *<option: Include other optional methods, such as EFT & credit card>*

Automatic deduction from your monthly Social Security or RRB benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

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

The fields in this section are optional

Answering these questions is your choice. You can’t be denied coverage because you don’t fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- | | |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican | <input type="checkbox"/> Yes, Cuban |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | |
| <input type="checkbox"/> I choose not to answer. | |

What's your race? Select all that apply.

☐ American Indian or Alaska Native

Asian:

☐ Asian Indian

☐ Chinese

☐ Filipino

☐ Japanese

☐ Korean

☐ Vietnamese

☐ Other Asian

☐ Black or African American

Native Hawaiian and Pacific Islander:

☐ Guamanian or Chamorro

☐ Native Hawaiian

☐ Samoan

☐ Other Pacific Islander

☐ White

☐ **I choose not to answer.**

What is your gender? Select one.

☐ Woman

☐ Man

☐ Non-binary

☐ I use a different term: _____

☐ **I choose not to answer**

Which of the following best represents how you think of yourself? Select one.

☐ Lesbian or gay

☐ Straight, that is, not gay or lesbian

☐ Bisexual

☐ I use a different term: _____

☐ I don't know

☐ **I choose not to answer**

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

_____ <include list of available languages>

_____ <include list of accessible formats (e.g. Braille, audio CD, data CD, or large print)>

Please contact <plan name> at <phone number> (TTY users should call TTY number> if you need information in an accessible format or language other than what is listed above.

Our office hours are <insert days and hours of operation>.

[*Optional:* If plan delivers some documents electronically, insert language explaining the types of documents it sends and how (e.g., information about your enrollment to the email address you provide to us on this form), as well as how a member can opt to get paper versions of those documents instead (e.g., a checkbox to opt-out of getting documents electronically).]

Signature:

Today's Date:

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

Name: _____

Address: _____

Phone Number: (____) _____ - _____
Relationship to Enrollee _____

Please mail this form to:
<Insert mailing address>

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name: _____ Relationship to enrollee: _____
Signature: _____ National Producer Number (Agents/Brokers only): _____

[optional space for other administrative information needed by plan]

Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment Request

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

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <plan name> 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 name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services as described in your member materials.

[Optional language: This letter is proof of insurance that you should show at your doctor appointments until you get your member card from us.] **[Optional language for MA-PD:** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[MA PPO plans use the following paragraph in place of 1st paragraph above: Thank you for enrolling in <Plan name>. Beginning <effective date>, you must get 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 described 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.]

What should I do now?

Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But, you shouldn't wait to get this letter before you begin using <plan name> doctors on <effective date>. Also, don't cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[MA-PD plans with a premium include the following: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.]

[Plans with a premium include the following:

How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly premium automatically deducted from your Social Security/Railroad Retirement Board benefit check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact

us at <plan telephone number>. TTY users should call <TTY number>.] *[MAOs that disenroll for non-payment of plan premiums include the following sentence: Members who fail to pay the monthly plan premium may be disenrolled from <plan name>.]*

What do I need to know about getting health care services?

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services.

[MA PPO 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 name> doctor without prior authorization, you will have to pay for these services yourself.]

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.]

[MA-PD plans with a premium include the following two paragraphs:

[Dual-eligible SNPs may omit the following paragraph]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.]

[Optional: What else do I need to know about my coverage?

If applicable, 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 <plan name> at <phone number>. TTY users should call <TTY number>. We are open <days/hours of operation and, if different, *TTY* hours of operation>.

Thank you.

Exhibit 4a: Model Notice to Acknowledge Receipt of Completed Enrollment Request – Enrollment in another Plan Within the Same Parent Organization

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

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 name> 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 <new plan name> doctor(s). You will need to pay your plan copayments at the time you get health care services. [*Optional*: This letter is proof of health insurance that you should show during your doctor appointments.] [*Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[*MA PPO plans use the following paragraph in place of 1st paragraph above*: Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Beginning <effective date>, you must get 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: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>] [*Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What should I do now?

Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <new plan name>. But, you shouldn't wait to get this letter before you begin using <new plan name> doctors on <effective date>.

[*MA PPO plans do not use the following sentence*: 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 name> doctor without prior authorization, you will have to pay for these services yourself.]

[*Zero premium plans do not include the following*:

How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly premium automatically deducted from your Social Security or Railroad Retirement

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.]*[MAOs that disenroll for non-payment of plan premium include the following sentence: "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]*

[MA-PD plans with a premium include the following: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.]

[MA-PD plans with a premium include the following paragraph:]

[Dual-eligible SNPs may omit the following paragraph]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.]

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 4b: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>.

How will this plan work?

Beginning <effective date>, you must see your <plan name> 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 name> 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. **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 name> doctor without prior authorization, you will have to pay for these services yourself.**

[MA PPO plans use the following paragraph in place of paragraph above: Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Beginning <effective date>, you must get 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: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] *[Optional language for MA-PD:* This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[MA-PD plans insert the following two paragraphs if no low-income subsidy:

What are my costs on this plan?

The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-

<Contract#, alpha-numeric identifier, “CMS Approved/File & Use” [date] (as applicable)>

0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[MA-PD plans add the following paragraph if low-income subsidy applicable:

What are my costs since I qualify for Extra Help?

Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the Extra Help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?

[MA-PD plans insert the following for new members with an existing LEP: Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.]

[MA-PD plans, if previous paragraph not applicable, insert the following for all other new members: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[Zero premium plans do not include the following:

How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact

us at <plan telephone number>. TTY users should call <TTY number>.]*[MAOs that disenroll for nonpayment of premium include the following sentence: “Members who fail to pay the monthly plan premium may be disenrolled from <plan name>”.]*

[MA-PD plans with a premium include the following: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [Zero premium plans do not include the following: We will bill you for the portion of your monthly premium that you owe.]

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.] [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.]

What if I have a Medigap (Medicare Supplement Insurance) policy?

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 Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 4c: Model Notice to Acknowledge Receipt of Completed PFFS Enrollment Request

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you will begin to get your healthcare from <plan name>. You must show your <Plan name> ID card to your doctor or hospital before you receive healthcare. You may no longer use your red, white and blue Medicare card to receive healthcare, because **Original Medicare won't pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place.

How will this plan work?

<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. <Plan name> 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. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except in emergencies. You may contact us at the phone number provided at the end of this letter for help locating another provider in your area. *[Optional language: You can also visit the <plan/organization name> website at <plan website address>.]*

[Include if plan uses a network of contracted providers: <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.]]

[*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. *Optional language for MA-PD*: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What should I do now?

Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But you shouldn't wait to get that letter before you begin seeing your <plan name> doctors on <effective date>. Also, don't cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[*Zero premium plans do not include the following*:

How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.] [*MAOs that disenroll for non-payment of plan premiums include the following sentence*: "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]

[*MA-PD plans with a premium include the following*: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [*Zero premium plans do not include the following*: We will bill you for the portion of your monthly premium that you owe.]

What do I need to know about getting health care services?

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services.

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*MA-PD plans with a premium include the following two paragraphs*:

What are my costs?

[*MA-PD insert the following if no low-income subsidy*: The monthly premium for your plan is <insert premium>. <Explain the charges for which the member will be liable, e.g., coinsurance,

fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance.>

[Dual-eligible SNPs may omit the following paragraph]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.]

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 4d: Model Notice to Acknowledge Receipt of Completed PFFS Enrollment Request and to Confirm Enrollment in a PFFS Plan

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

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>.

How will this plan work?

<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. <Plan name> 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. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except in emergencies. You may contact us at the phone number provided at the end of this letter for help locating another provider in your area.

[Include if plan uses a network of contracted providers: <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.]]

[Optional: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. Optional language for MA-PD: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

[MA-PD plans insert the following two paragraphs if no low-income subsidy:

What are my costs on this plan?

The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[MA-PD, if low-income subsidy applicable:

What are my costs since I qualify for Extra Help?

Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that that the Extra Help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?

[MA-PD plans insert the following for new members with an existing LEP: Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.]

[MA-PD plans, if previous paragraph not applicable, insert the following for all other new members:

The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[Zero premium plans do not include the following:

How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <plan telephone number>. TTY users should call <TTY number>.]*[MAOs that disenroll for non-payment of plan premiums include the following sentence: Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".]*

[MA-PD plans with a premium include the following: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [Zero premium plans do not include the following: We will bill you for the portion of your monthly plan premium that you owe.]

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.]

[If applicable, please insert information instructing member in simple terms 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.]

What if I have a Medigap (Medicare Supplement Insurance) policy?

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 Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to leave (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 4e: Model Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment in Another Plan Within the Same Parent Organization

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Name of Member>:

Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Medicare has approved your enrollment in <new plan name> beginning <effective date>.

How will this plan work?

Beginning <effective date>, you must see your <new plan name> 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 <new plan name> 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. **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 name> doctor without prior authorization, you will have to pay for these services yourself.**

[MA PPO plans use the following paragraph in place of paragraphs above: Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Medicare has approved your enrollment in <new plan name> beginning <effective date>. Beginning <effective date>, you must get 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: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] *[Optional language for MA-PD:* This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

[MA-PD plans insert the following two paragraphs if no low-income subsidy:

What are my costs on this plan?

The monthly premium for your plan is <insert premium>.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local

Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.]

[MA-PD plans add the following paragraph if low-income subsidy applicable:

What are my costs since I qualify for Extra Help?

Because you qualify for Extra Help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the Extra Help amounts should be different, please contact <plan name>.]

Will I pay a late enrollment penalty as part of my premium?

[MA-PD plans insert the following for new members with an existing LEP: Your premium continues to reflect a late enrollment penalty amount that was based on information we had from your previous enrollment in <old plan name>. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.]

[MA-PD plans insert the following for new members who don't have an existing LEP:

The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

As you did not previously have a late enrollment penalty with us, you will not have a late enrollment penalty with this enrollment change.]

[Zero premium plans do not include the following:

How do I pay my premium?

Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact

us at <plan telephone number>. TTY users should call <TTY number>.]*[MAOs that disenroll for nonpayment of premium include the following sentence: “Members who fail to pay the monthly plan premium may be disenrolled from <plan name>”.]*

[MA-PD plans with a premium include the following: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.] [Zero premium plans do not include the following: We will bill you for the portion of your monthly premium that you owe.]

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Plans have the option to omit this language for non-ICEP enrollments: If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.]

[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.]

What if I have a Medigap (Medicare Supplement Insurance) policy?

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 Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 5: Model Notice to Request Information

Dear <Name of Member>:

Thank you for applying with <plan name>. We need additional information from you. Please see the checked items below.

We cannot process your application until we get the following things from you:

- _____ Proof of Medicare coverage. Please provide us your Medicare Number. Your Medicare Number is printed on your Medicare card. You can also get your number by:
 - Logging into your ssa.gov/myaccount or MyMedicare.gov accounts;
 - Calling Medicare at 1-800-MEDICARE (1-800-633-4227; TTY: 1-800-486-2048); or
 - Calling Social Security at 1-800-772-1213 (TTY: 1-800-325-0778).
- _____ During certain times of the year, Medicare doesn't let you enroll unless you meet certain special exceptions, such as if you qualify for extra help with your prescription drug costs. Please call us at the number below to help us determine if you're able to enroll at this time.
- _____ Other: _____

You will need to send this information to <plan name and address> by <date>. You can contact us by phone with this information by calling the phone number below. Or, you may also fax it to us at <fax number> or send it to us at <address>. If we don't get this information by <date>, we will have to deny your request to enroll in our plan.

If you have any questions, please call <plan name> 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 (MA-PD)

<Member # >

<RxID>

<RxGroup>

<RxBin>

<RxPCN>

Dear <Name of Member>:

Please be sure to keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

[If no low-income subsidy:

What are my costs in this plan?

The monthly premium for your plan is: <premium amount>.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.ssa.gov/medicare/part-d-extra-help.

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

[If low-income subsidy applicable:

What are my costs since I qualify for extra help?

Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

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

Will I pay a late enrollment penalty as part of my premium?

[Insert the following for new members with an existing LEP:

Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.] If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.

[If previous paragraph not applicable, insert the following for all other new members: If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?

Now that we have confirmed your enrollment, you may cancel any Medigap policy or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

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

Thank you.

Exhibit 6a: Model Notice to Confirm Enrollment - Plan to Plan Within Parent Organization

Dear <Name of Member>:

Please keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

[MA-PD, if no low-income subsidy:

What are my costs in this plan?

The monthly premium for your plan is <premium amount>.

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.ssa.gov/medicare/part-d-extra-help.

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

[MA-PD, if low-income subsidy applicable:

What are my costs since I qualify for extra help?

Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

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

Will I pay a late enrollment penalty as part of my premium?

[MA-PD plans insert the following for members with an existing LEP: Your premium continues to reflect a late enrollment penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[MA-PD plans, if previous paragraph not applicable, insert the following for all other new members: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they

are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

[Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance]

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

Thank you.

Exhibit 6b: Model Notice for MA-PD Plans for Individuals Identified on CMS Records As Members of Employer or Union Group Receiving the Retiree Drug Subsidy (RDS)

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 name>.

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

It is important that you consider your decision to enroll in our plan carefully, since enrollment in <plan name> could affect your employer or union health benefits. You could lose your employer or union health coverage. If you haven't already done so, please contact your benefits administrator to discuss your decision to enroll in a Medicare prescription drug plan.

[*PFFS plans insert:* <Plan Name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

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 name>, **please call <plan name> at the phone number provided below. Your enrollment won't be complete until you call and confirm this information.** Your effective date will be <effective date>.

We must hear from you to enroll you in our plan. If we don't hear from you within 30 days from the date of this notice, we won't process your enrollment. If you decide not to enroll in <plan name> you will be responsible for any services you have already received from <plan name>.

To confirm your enrollment or if you have any questions, please feel free to contact <plan name> at <phone number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

Exhibit 6c: Model Notice to Confirm PFFS Enrollment

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

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. You must show your <Plan name> ID card to your doctor or hospital before you get healthcare. Don't use your red, white, and blue Medicare card to receive healthcare, because **Original Medicare won't pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place. [Optional: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.] [Optional language for MA-PD: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

How does this plan work?

<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan and other Medicare Advantage plans. As we told you before, <Plan name> 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. You should contact your doctor or hospital to ask whether they will accept our plan's payment terms. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <plan name> before each visit. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.

If any doctor or hospital provides health care services to you after learning about our plan's payment terms, they must bill us for services, and aren't allowed to send the entire bill to you. If a doctor or hospital does provide services to you, then they are considered to have accepted our plan's terms. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials.

If your doctor or hospital doesn't accept our plan's payment terms, they shouldn't provide services to you except for emergencies. You may contact us at the number at the end of this letter for help locating another provider in your area.

[Include if plan uses a network of contracted providers: <Plan name> has direct contracts with some providers who have already agreed to accept our terms and conditions of payment. [Describe what category or categories of providers the plan has under direct contract and how members can get the list of contracted providers.] You can still get care from other providers who do not contract with <plan name> as long as those providers agree to accept our terms and conditions of payment. [Indicate if the plan has established higher cost sharing requirements for members who obtain covered services from non-contracted providers.]

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

[MA-PD, if no low-income subsidy:

What are my costs in this plan?

The monthly premium for your plan is <premium amount>. *[Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance]*

[MA-PD, if no low-income subsidy:

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.ssa.gov/medicare/part-d-extra-help.

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

[MA-PD, if low-income subsidy applicable:

What are my costs since I qualify for extra help?

Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

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

Will I pay a late enrollment penalty as part of my premium?

[MA-PD plans insert the following for new members with an existing LEP: Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <plan name> at the phone number provided at the end of this letter. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[MA-PD plans, if previous paragraph not applicable, insert the following for all other new members: The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum

standards. You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

If we determine that you owe a late enrollment penalty, we will notify you of your new monthly premium amount.]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?

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 Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

If you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Please be sure to keep a copy of this letter for your records.

Thank you.

Exhibit 6d: Model Notice to Confirm Enrollment (MA-only)

<Member # >

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Please be sure to keep a copy of this letter for your records.

What are my costs in this plan?

[MA-only plans with a premium insert the following:

The monthly premium for your plan is: <premium amount>.]

[Explain the charges for which the prospective member will be liable, e.g., coinsurance, fees or other amounts, and any amount that is attributable to the Medicare deductible and coinsurance]

What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?

Now that we have confirmed your enrollment, you may cancel any Medigap policy or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information about Medigap policies. TTY users should call 1-877-486-2048.

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

Thank you.

Exhibit 7: Model Notice for MA Organization Denial of Enrollment

Dear <Name of Beneficiary>:

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

1. _____ You don't have Medicare Part A.
2. _____ You don't have Medicare Part B.
3. _____ You are unlawfully present in the United States.
4. _____ You are incarcerated and currently reside outside our service area.
5. _____ Your permanent residence is outside our service or continuation area.
6. _____ You attempted to enroll outside of an enrollment period or don't qualify for an enrollment period at this time.
7. _____ We didn't get the information we requested from you within the timeframe listed in our request.
8. _____ The request was made by someone other than the beneficiary and that individual isn't the beneficiary's authorized representative.
- [9. _____ **MA-PD plans only:** You are not eligible to enroll in prescription drug coverage at this time.]
- [10. _____ **MA-PD plans only:** You have drug coverage from your employer or union and you told us you don't want to join <MA plan>.]
- [11. _____ **Special needs plans only:** You are not eligible for this Special Needs Plan because you don't <insert special needs criteria>.]

If <plan name> paid for any of your health care services, then we will bill you for the amount paid.

[Insert if item 3 or 4 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U.S. or if you're incarcerated.]

[Insert if item 6, 7, 8, or 9 is selected: You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want

to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.]

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you believe any of the checked items are wrong, or if you have any questions, please call <plan name> 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

Dear <Name of Beneficiary>:

[If sending in place of combined acknowledgement/confirmation notice, insert the following sentence: Thank you for your request to enroll in <plan name>.] Medicare has denied your enrollment in <MA Plan> due to the reason(s) checked below:

1. _____ You don't have Medicare Part A
2. _____ You don't have Medicare Part B
3. _____ You are unlawfully present in the United States.
4. _____ You are incarcerated and currently reside out of our service area.
5. _____ You attempted to enroll outside of an enrollment period or you don't qualify for an enrollment period at this time.
6. _____ You requested to enroll in a different plan for the same effective date, which canceled your application with <plan name>.

If <plan name> paid for any of your health care services, then we will bill you for the amount paid.

[Insert if item 3 or 4 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U.S. or if you're incarcerated.]

[Insert if item 5 is checked: You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.]

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help. If you believe any of the checked items are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

Thank you.

Exhibit 9: Model Notice to Send Out Disenrollment Form (MA-PD enrollee)

Dear <Name of Member>:

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

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

What is Extra Help?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

When should I fill out the disenrollment request form?

- You **should** fill out the attached form if you want to change to Original Medicare only and do not want Medicare prescription drug coverage.
- You **shouldn't** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage plan or other Medicare health plan. Enrolling in another Medicare plan will automatically disenroll you from our plan.
- You **shouldn't** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.

Until your disenrollment date, you must keep using <plan name> 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 <plan name>'s network.

How do I submit the disenrollment request?

If you want Original Medicare, as described above, 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 call 1-800-MEDICARE (1-800-633-4227) for information about Medicare plans available in your area. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

What are my Medigap rights?

If you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap policy, also known as Medicare supplemental 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 Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week 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 9a: Model Notice to Send Out Disenrollment Form (MA-only enrollee)

Dear <Name of Member>:

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

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

*[Dual eligible Special Needs Plans may omit this paragraph: **What is Extra Help?***

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.]

When should I fill out the disenrollment request form?

You **should** fill out the attached form if you want to change to Original Medicare only and don't want Medicare prescription drug coverage.

You **shouldn't** fill out the attached form if 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 <plan name>.

*[MA-only coordinated care plans insert: You **shouldn't** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.]*

[MSA plans insert: Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

Until your disenrollment date, you must keep using <plan name> 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 <plan name>'s network.

How do I submit the disenrollment request?

If you want Original Medicare, as described above, 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 call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for information about Medicare plans available in your area. TTY users should call 1-877-486-2048.

What are my Medigap rights?

If you will be changing to Original Medicare, 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 Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you need any help, please call <plan name> 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

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

Last name:	First Name:	Middle Initial:
Medicare Number: (Note: may use "Member Number" instead of "Medicare Number")		
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:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in <MA plan name> on the effective date of that new enrollment. 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 want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Your Signature*: _____ **Date:** _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. 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> or by Medicare.

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

Name: _____
Address: _____
Phone Number: () ____ - ____
Relationship to Enrollee _____

Exhibit 10a: Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I am joining a PACE program on (insert date) _____.
- ☐ I am joining employer or union coverage on (insert date) _____.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

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

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

Dear <Name of Beneficiary>:

We received your request to disenroll from <plan name>. You will be disenrolled starting <effective date>. Beginning <effective date>, <plan name> won't cover any health care you get. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans insert:* When coverage from <plan name> ends, your <plan name> prescription drug coverage ends too. **If you don't take any action, you will be covered by Original Medicare beginning <effective date>.** To have new health care coverage and prescription drug coverage on <effective date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. For example, if you are returning to Original Medicare and want Medicare prescription drug coverage, you must join a Medicare prescription drug plan. If you don't enroll in a Medicare prescription drug plan on your own and you have both Medicare and Medicaid, Medicare will enroll you in a Medicare prescription drug plan, unless you tell the plan you don't want to join. If you don't enroll in another Medicare Advantage plan with prescription drug coverage or Medicare prescription drug plan, or if you don't get creditable coverage as good as Medicare prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*MA-only plans insert:* Disenrolling from <plan name> doesn't affect any prescription drug coverage you may have. To have new health care coverage on <effective date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. If you don't take any action, you will be covered by Original Medicare beginning <effective date>.]

[*MSA plans insert the following:* Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

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 <plan name> and there may be a short delay in updating your records.

Information About Medigap Rights

If you will be changing to Original Medicare 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 Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP

phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. 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>.

[Dual eligible Special Needs Plans may omit this paragraph: Did you know that people with limited incomes may qualify for extra help to pay for their prescription drug costs? If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.ssa.gov/medicare/part-d-extra-help.]

Thank you.

Exhibit 11a: Model Notice to Request Information (Disenrollment)

Dear <Name of Member>:

We received your request to disenroll from <plan name>. However, it is missing information that will help us to determine if we can accept your request. We cannot process your disenrollment without this information.

Please review the checked item(s) below and contact us immediately.

_____ Medicare requires that you sign your written disenrollment request. The request we received from you didn't include a signature. Please call us at the number below to confirm that you want to disenroll from <plan name>.

_____ During certain times of the year, Medicare doesn't let you disenroll unless you meet certain special exceptions, such as if you qualify for extra help with your prescription drug costs. Please call us at the number below to help us determine if you're able to disenroll at this time.

_____ The request we received was from someone other than you and that individual isn't listed as your authorized representative. Please call us at the number below so that we may confirm your request to disenroll.

_____ Other: _____

If you have any questions about the information in this letter or would like to provide us with information to help us process your disenrollment request, you may contact us by telephone or mail:

<plan name>

<mailing address>

<toll free number and days/hours of operation>

<TTY toll-free number>

You may also fax us information at <fax number>.

If we don't get this information, we will have to deny your request to disenroll from our plan.

Instead of sending a disenrollment request to <plan name> you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week to disenroll by telephone. TTY users should call 1-877-486-2048. If you're receiving coverage through your employer, you should contact your employer instead of calling 1-800-MEDICARE to find out how this affects your retiree benefits.

Thank you.

Exhibit 12: Model Notice to Confirm Voluntary Disenrollment Following Receipt of Daily Transaction Reply Report (DTRR)

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <MA Plan>. Beginning <effective date,> <plan name> won't cover your health care. 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 recently disenrolled from <plan name>.

[MA-PD plans insert the following: If your <plan name> premium is being deducted from your Social Security or Railroad Retirement Board benefit, please allow up to 3 months for Social Security or the Railroad Retirement Board to process a refund. If you have not received a refund within 3 months of this letter, you should contact 1-800-MEDICARE.]

[MSA plans insert the following: Please note that if you disenroll before the end of the year, you (or your estate) will have to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time you enrolled. The amount you owe is based on the number of months left in the year after your disenrollment date.]

INFORMATION ABOUT MEDIGAP RIGHTS

If you will be changing to Original Medicare 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 Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

If you think you didn't disenroll from <plan name>, and you want to keep being a member of <plan name>, please call us right away at <phone number> so we can make sure you stay a member of <plan name>. Medicare gives you only 30 days from the date of this letter to contact us. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

[Dual eligible Special Needs Plans may omit this paragraph: Did you know that people with limited incomes may qualify for extra help to pay for their prescription drug costs? If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.]

Thank you.

Exhibit 12a: Model Notice for MA Organization Denial of Disenrollment

Dear <Name of Beneficiary>:

We recently got your request to disenroll from <plan name>. We cannot accept your request for disenrollment because:

1. _____ You have attempted to make a change outside of an enrollment period or you don't qualify for an enrollment period at this time.
2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below).
3. _____ We didn't get the information we requested from you within the timeframe listed in our request.
4. _____ The request was made by someone other than the enrollee and that individual isn't the enrollee's authorized representative.

When can I make changes to my coverage?

There are limits to when and how often you can change the way you get Medicare.

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31**, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following paragraph:]

What is extra help?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you believe any of the items we checked 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>.

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

Thank you.

Exhibit 12b: Model Notice for CMS Rejection of Disenrollment

Dear <Name of Beneficiary>:

Medicare has denied your disenrollment from <plan name> due to the reason(s) checked below:

1. _____ You have attempted to make a change outside of an enrollment period or you don't qualify for an enrollment period at this time.
2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

When can I make changes to my coverage?

There are limits to when and how often you can change the way you get Medicare.

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31**, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following paragraph:]

What is extra help?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you believe any of the items we checked are wrong, or if you have any questions, please call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 12c: Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan

IMPORTANT INFORMATION ABOUT YOUR UPCOMING DISENROLLMENT FROM YOUR MEDICARE ADVANTAGE PLAN

<Date>

Dear <Name of Member>:

Your state has enrolled you into a new plan that will provide all of your Medicare and Medicaid benefits, including prescription drugs. You should have already gotten a letter from your state telling you about the new plan.

This letter confirms your disenrollment from <MA plan name>. You will continue to get your Medicare benefits from <MA plan name> until <disenrollment effective date>. Beginning <day following disenrollment effective date>, your new plan will cover your health care.

You will be automatically enrolled in your new plan starting <day following disenrollment effective date>, so you don't have to do anything if you want to be a member of this new plan. In a few weeks, you should get a letter from your new plan confirming your enrollment. **There will be no gap in your Medicare and Medicaid coverage** [MA-PD plans insert the following: including your prescription drug coverage].

The letter from your new plan will tell you how to contact them. You can call your new plan with questions about your new coverage or to see if you can still see your current doctors in your new plan. You can also ask for lists of network primary care providers, covered drugs and pharmacies.

If you have questions about your disenrollment from <MA plan name>, please call us at <phone number> (TTY users should call <TTY number>). We are open <days and hours of operation>. If you do not wish to be automatically enrolled in a new plan, call your state or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use a TTY. You can also call 1-800-MEDICARE if you have questions about Medicare or need help with your Medicare options.

Thank you.

Exhibit 13: Model Notice of Disenrollment Due to Death

To the Estate of <Member Name>:

Medicare told us of the death of <Member's Name>. Please accept our condolences.

<Member's name>'s coverage in <plan name> [ended; will end] as of <effective date>. If plan premiums were paid for any month after <effective date>, we will issue a refund to the Estate within 30 days of this letter.

[MA-PD plans insert the following: If the <plan name> premium is being deducted from <Member Name>'s Social Security or Railroad Retirement Board benefit, please allow up to 3 months for Social Security or the Railroad Retirement Board to process a refund. If the estate has not received a refund within 3 months of this letter, a representative of the estate should contact 1-800-MEDICARE anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

[MSA plans insert the following: Please note that the Estate has to pay <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time of enrollment. The amount owed is based on the number of whole months left in the year after the date of death.]

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>.

Thank you.

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

Dear <Name of Member>:

Medicare has told us that you [will] 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 <plan name> [ended; will end] on <date>. If this information is wrong, and you want to stay a member of our plan, please contact us. Also, if you haven't already done so, please contact your local Social Security office to have their records corrected.

[*MA-PD plans insert:* When coverage from <plan name> [ends; ended] on <date>, your Medicare prescription drug coverage [will end; ended] too. If you still have either Medicare Part A or Medicare Part B you are eligible for Medicare prescription drug coverage. To get Medicare prescription drug coverage, you must enroll in a Medicare prescription drug plan such as a Medicare Advantage Plan with prescription drug coverage or a Medicare Prescription Drug Plan. If you are eligible to join a Medicare prescription drug plan but don't join, and you don't have other drug coverage that is at least as good as Medicare's, you may have to pay a late enrollment penalty if you join later. This means you pay a higher premium for as long as you have Medicare prescription drug coverage. Remember, Medicare limits how and when you can make changes to your coverage. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.]

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

Dear< Name of Member>:

Medicare records incorrectly show you as deceased.

If you haven't already done so, please go to your local Social Security Office and ask them to correct your records. Please send us written proof at <address> after you do this. When we get this proof, we will share it with Medicare.

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. MA plans may insert "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 <plan name>.

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

Dear < Name of Member>:

On <date of request> you told us that your enrollment in Medicare was ended in error and that you want to stay a member of <plan name>.

[Organizations that are able to verify current Medicare entitlement may omit the following:

To do this, please complete the following three steps no later than <insert date: 60 days from date of disenrollment notice>:

1. Contact Social Security 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 Social Security to give you a letter that says they have fixed your records.
3. Send the letter from Social Security to us at: <address of MA Plan> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we get this letter, we will tell the Medicare to correct its records.]

[Organizations that are able to verify current Medicare entitlement insert: Social Security corrected the error. We will tell Medicare to correct its records.]

In the meantime, you should keep using your <plan name> primary care physician for your health care. [Note: If PCP not applicable, omit this sentence. MA plans may insert “physicians” or “doctors” or “providers” instead of “primary care physician,” if that is more appropriate.]

[Organizations that are able to verify current Medicare entitlement omit the following:

If we find out that you don’t have Medicare Part <insert “A” and/or “B” as appropriate>, or if we don’t get proof that you have Medicare by <insert date: 60 days from date of disenrollment notice>, you will have to pay for any service you got after <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 <plan name>.

Exhibit 17: Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error

Dear <Name of Member>:

Thank you for letting us know that you want to remain a member of <plan/sponsor name> after we mistakenly [*select one based on the circumstance*: disenrolled you from/cancelled your enrollment in] our plan. [*Insert brief summary of the plan error that caused the disenrollment.*] We apologize for the inconvenience. We have changed our records to show that you are still a member of <plan/sponsor name>. You should keep seeing your <plan name> [*insert appropriate term*: <primary care physician, physicians, doctors, providers, pharmacies, etc.>] for your health care.

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 <plan name>.

Exhibit 18: Model Notice to Close Out Request for Reinstatement

Dear <Name of Beneficiary>:

We cannot process your request to be in <plan name> again because we haven't gotten the information we requested. As discussed in our letter of <date of letter> you must send us this information by <date placed on notice in Exhibit 16> to remain a member of our plan.

You were no longer a member of our plan as of <effective date>. If <plan name> paid for any services after this disenrollment date, we will have to bill you for those services.

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

Thank you.

Exhibit 19: Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage of Optional Supplemental Benefit(s)

Dear <Name of Member>:

Our records show that we haven't gotten payment for your plan premium as of <premium due date>.

[MA organizations who will disenroll all members (and not use the downgrade option) use the following sentences: If we don't get payment by <date grace period expires>, we will have to disenroll you from <plan name>, effective <disenrollment date>. After <disenrollment date> you will be covered by Original Medicare instead of <plan name>.]

[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 reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefit(s) use the following sentences: If we don't get payment by <date grace period expires>, we will make some changes to your membership in <plan name> that will reduce the amount of health care coverage you have in <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.]

[Insert if applicable in state where member resides: If you get medical assistance (Medicaid) from your State (including paying your premiums, deductibles, or coinsurance), you should check with your 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 about Medigap policies, 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 <plan name> and change to Original Medicare now, you should do one of these two things:

1. Send us a written request at <MA Plan address>.
2. Call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31**, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

If you paid the premium recently and 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>.

Thank you.

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

Dear <Name of Member>:

On <date> we sent you a letter that said your plan premium was overdue. The letter said that if we didn't get payment from you, we would disenroll you from <plan name>. Since we didn't get that payment, we asked Medicare to disenroll you from <plan name> beginning <effective date>. You will be covered by Original Medicare beginning <effective date>.

[MA PFFS do not include this paragraph: Please note that until <disenrollment effective date>, you must keep using <plan name> doctors except for emergency or urgently needed care or out-of-area dialysis services. After that date, you can see any doctor through Original Medicare, unless you join a Medicare Advantage plan or another Medicare health plan.]

What if I think there's been a mistake?

If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

I had an emergency that kept me from sending my payment. What can I do?

You can ask us to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If we approve your request, you will have to pay all owed premium amounts within three (3) months of your disenrollment in order to get your coverage back. To ask us to review this decision, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. You must make your request no later than <insert the date that is 60 calendar days after the disenrollment effective date>.

When can I make changes to how I get my Medicare coverage?

Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[MA-PD plans insert: Please remember, if you don't have other creditable coverage (prescription drug coverage expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[Dual-eligible SNPs may omit the following paragraph:]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who

qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

For more information:

If you have any questions or if you have recently sent us a payment, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

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

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <plan name> because you didn't pay your plan premium. Your disenrollment begins <effective date>. You are now enrolled in Original Medicare.

What if I think there's been a mistake?

If you think that we have made a mistake, please call us at <phone number>. You also have the right to ask us to reconsider your disenrollment through the grievance procedure written in your <insert "Member Handbook" or "Evidence of Coverage," as appropriate>.

I had an emergency that kept me from sending my payment. What can I do?

You can ask us to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If we approve your request, you will have to pay all owed premium amounts within three (3) months of your disenrollment in order to get your coverage back. To ask us to review this decision, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. You must make your request no later than <insert the date that is 60 calendar days after the disenrollment effective date>.

When can I make changes to how I get my Medicare coverage?

Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[*MA-PD plans insert:* Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph:*]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

For more information:

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

Thank you.

Exhibit 21a: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount

Important – You have been disenrolled from your Medicare Advantage Prescription Drug Plan

<Date>

Dear <Beneficiary Name>:

Medicare has disenrolled you from <MA-PD plan name> because you didn't pay the extra amount (called the Part D-Income Related Monthly Adjustment Amount or Part D-IRMAA). As of <effective date>, you will no longer have coverage through <MA-PD plan name>. Your Medicare prescription drug coverage will also end on the same date. Since the disenrollment has already processed, you can't pay the owed amounts now to keep your Part D coverage.

Before you were disenrolled, Medicare (or the Railroad Retirement Board) sent you notices that showed the amount that you owed and provided information on how to pay this amount. If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, not by <plan name>.

What if I think there's been a mistake?

If you paid the Part D-IRMAA or think that there has been a mistake, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

I had an emergency that kept me from sending my Part D-IRMAA payment. What can I do?

You can ask Medicare to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If Medicare approves your request, you will have to pay all Part D-IRMAA and plan premium amounts owed within three (3) months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) to make a request as soon as possible, but no later than <insert the date that is 60 calendar days after the disenrollment effective date>. TTY users should call 1-877-486-2048.

Please remember, if you don't request reinstatement within 60 days and pay all owed amounts within 3 months, you will not get your coverage back and will have to wait for another opportunity to enroll. If you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty in addition to the monthly Part D-IRMAA and plan premium, if you enroll in Medicare prescription drug coverage in the future.

When can I get Part D coverage?

Medicare limits when you can make changes to your coverage. **From October 15 through December 7 of each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

Who can I call to get more information?

You can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week if you have questions about your disenrollment because you didn't pay the Part D-IRMAA. TTY users should call 1-877-486-2048. You can also call <plan name> at <phone number> if you have questions about your plan's premium. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

Exhibit 22: Model Notice on Failure to Pay Optional Supplemental Benefit Premiums - Notice of Reduction in Coverage of Optional Supplemental Benefit(s) Within the Same Plan (PBP)

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 didn't get payment from you, we would have to make some changes in your membership in <plan name>. Our records show that we did not get payment from you as of <date>. Therefore, we have reduced your coverage in <plan name>, beginning <effective date>.

<Explain in simple terms lower level of benefits, e.g., routine dental care won't 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>.

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

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31**, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

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>.

Thank you.

Exhibit 22a: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Plan Premium Amount Due for Reinstatement

Dear <Name of Member>:

Medicare has notified us that you received a favorable decision on your request for reinstatement into <plan name>. Our records show that we haven't gotten payment for your plan premium as of <premium due date>. In order for your coverage to be reinstated, we must receive payment in the amount of <enter amount owed> no later than <date 3 months from the effective date of disenrollment>.

This amount is due in addition to the amounts you owe <Medicare or RRB> for your Part D-IRMAA. You do not pay us your owed Part D-IRMAA amounts. <Medicare or RRB> will send you a letter regarding the amount you owe and how you can pay. You must pay <Medicare or RRB> this amount by <date 3 months from the effective date of disenrollment> to be reinstated.

[MA organizations that include a payment coupon with the letter, insert the following sentences: You can mail your payment to us using the enclosed coupon. Be sure to make full payment of your owed amount and include your member number on the check.]

[MA organizations that do not include a payment coupon with the letter, insert the following sentences: You can mail your payment to us at the following address: <billing address>. Be sure to make full payment of your owed amount and include your name and [insert one: member number/billing number/ID number] on the check.]

If we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>. You will be covered by Original Medicare instead of <plan name>.

When can I make changes to how I get my Medicare coverage?

Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[MA-PD plans insert: Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who

qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

For more information:

If you have any questions regarding the plan premium amount you owe and how you can pay, please call <plan name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 22b: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Plan Premium Amount Due for Reinstatement

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been approved. Our records show that we haven't gotten payment for your plan premium as of <premium due date>. In order for your coverage to be reinstated, we must receive payment in the amount of **<enter amount owed> no later than <date 3 months from the effective date of disenrollment>**.

[MA organizations that include a payment coupon with the letter, insert the following sentences: You can mail your payment to us using the enclosed coupon. Be sure to make full payment of your owed amount and include your member number on the check.]

[MA organizations that do not include a payment coupon with the letter, insert the following sentences: You can mail your payment to us at the following address: <billing address>. Be sure to make full payment of your owed amount and include your name and [insert one: member number/billing number/ID number] on the check.]

If we don't get payment by <date 3 months from the effective date of disenrollment>, you will remain disenrolled from <plan name>. You will be covered by Original Medicare instead of <plan name>.

When can I make changes to how I get my Medicare coverage?

Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[MA-PD plans insert: Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[Dual-eligible SNPs may omit the following paragraph:

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213.

TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help/]

For more information:

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

If you have any questions regarding the plan premium amount you owe and how you can pay, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 22c: Model Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been denied. This is because *[Insert one of the following: your request doesn't meet the criteria for reinstatement OR [Insert if unable to make a decision based on the original request and unable to reach beneficiary: we were not able to reach you to get the information needed to see if your circumstances meet the criteria for reinstatement.]* This means you'll remain disenrolled from your plan. This decision is final and can't be appealed.

You are still responsible for paying the plan premiums you owed at the time you were disenrolled.

When can I make changes to how I get my Medicare coverage?

Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[MA-PD plans insert: Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[Dual-eligible SNPs may omit the following paragraph:

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.]

For more information:

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

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 22d: Model Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

<Date>
<Beneficiary full name>
<Address>
<City, State Zip>

Dear <Beneficiary Name>:

We recently sent you a letter letting you know that we gave you a favorable decision on your request to get your coverage back.

The letter told you that in order to be reinstated into <plan name>, you had to pay all plan premiums you owe by <insert date 3 months after disenrollment effective date>. The amount owed was <\$ insert total premium amount owed>. The letter also told you that if we didn't get full payment by the deadline, you would stay disenrolled [*insert if Part D coverage included in plan*: and you would not have Medicare prescription drug coverage].

Your Payment Wasn't Received on Time

Because you didn't pay the full amount you owe by the deadline, you will stay disenrolled from your Medicare plan. This decision is final and can't be appealed.

You are still responsible for paying the plan premiums you owed at the time you were disenrolled.

When can I make changes to how I get my Medicare coverage?

Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

[*MA-PD plans insert*: Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

[*Dual-eligible SNPs may omit the following paragraph*:

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a Part D late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.]

For more information:

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

If you think we have made a mistake, or if you have any questions, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

For questions about making changes to the way you get Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 22e: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement)

<Member # >

[Insert RxID, RxGroup, RxBin and RxPCN if individual is being reinstated into Part D coverage]

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been approved. Our records show that we received the plan premium you needed to pay in order for your coverage to be reinstated.

We have updated our records to show that you are enrolled in <plan name> with no break in coverage. We will ask Medicare to correct its records to show the same.

You should keep using your <plan name> primary care physician for your health care. *(If PCP not applicable, terms such as “physicians” or “doctors” or “providers” may be used instead of “primary care physician.”)*

If you have any questions about your plan premium and how you can pay, please call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you for your continued membership in <plan name>.

Exhibit 23: Model Notices for Closing Enrollment

Model A: Closing Enrollment for Partial Month(s)

<MA organization> PUBLIC NOTICE

As of <date> <MA organization> will no longer offer continuous open enrollment under its Medicare Advantage contract with Medicare for <plan name> in <service area>.

Instead, <MA organization> will offer open enrollment for all eligible individuals from the <insert date> to the <insert date> of each month.

<MA organization> will continue to accept enrollments into <plan name> during an entire month from people who meet certain special exceptions, such as if someone moves out of the plan's service area or qualifies for extra help with prescription drug costs.

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals from October 15 through December 7.

Current members of <plan name> aren't affected by this change. For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

Model B: Closing Enrollment for Whole Month(s)

<MA organization> PUBLIC NOTICE

As of <date> <MA organization> will no longer offer open enrollment under its Medicare Advantage contract with Medicare for <plan name> in <service area>.

However, <MA organization> will continue to accept enrollments into <plan name> from eligible individuals who are in a Special Election Period or an Initial Coverage Election Period.

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals during the Annual Election Period from October 15 through December 7.

Current members of <plan name> aren't affected by this change. For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>. Thank you.

Model C: Closing Enrollment for Capacity Reasons

<MA organization> PUBLIC NOTICE

As of <date>, <MA organization> will no longer accept enrollment under its Medicare Advantage contract with Medicare for <plan name> in <insert service area>.

<MA organization> is limiting enrollment in <plan name> so plan members have greater access to providers and services.

Current members of <plan name> aren't affected by this change. Also, individuals who are enrolled in other <MA organization> plans may still be able to enroll in <plan name> when they become eligible for Medicare.

For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

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

Dear <Name of Beneficiary>:

This is to confirm that you disenrolled from <plan name> effective <date> and returned to Original Medicare because of the special circumstances indicated below:

_____ You permanently moved.

_____ You get help 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.

[Information about Medigap rights]

Since you will be changing to Original Medicare, you might have a special temporary right to buy a Medigap (Medicare supplement insurance) policy, 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 Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.]

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

Dear <name of applicant>:

As requested, we have cancelled your request to enroll with <plan name>.

Please be patient. It may take up to 45 days for Medicare to update your records. If you are in Original Medicare, 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.

Important: If you were enrolled in another Medicare Advantage plan or Medicare prescription drug plan before enrolling with <plan name>, you should be automatically enrolled back into that plan.

If you don't receive an enrollment acknowledgement letter from your previous plan within two (2) weeks of receiving this letter, please contact them to confirm your enrollment. They may request a copy of this letter for their records.

Please remember that if you don't have or get Medicare prescription drug coverage or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

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

Thank you.

Exhibit 25a: Model Acknowledgment of Reinstatement

Dear <member name>:

Please be sure to keep a copy of this letter for your records.

Medicare has enrolled you back in <plan name> with no break in coverage as of <effective date>.

[If PCP not applicable, omit following sentence. Terms such as “physicians” or “doctors” or “providers” may be used instead of “primary care physician”:] You should keep using your <plan name> primary care physician for your health care.]

[Insert one of the following sentences depending on plan policy: We will be sending you a new membership card and other important documents for <plan name>. *or* You can continue using the <plan name> membership card that you currently have. *or* If you no longer have your membership card, contact us at the number below to get a new card.]

[Insert information regarding plan premiums required to maintain enrollment, or use the following language: The monthly premium for <plan name> is <monthly premium amount>. You must pay this premium amount each month to remain enrolled in our plan. For more information regarding our disenrollment policy for non-payment of plan premiums, please see our policy written in your <insert “Member Handbook” or “Evidence of Coverage”, as appropriate>.]

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

Thank you for your continued membership in <plan name>.

Exhibit 25b: Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015)

<Date>

Dear <name of applicant>:

Medicare has told us that you have canceled your enrollment in <plan name> effective <insert date of enrollment that was canceled>. If this information is wrong, and you want to stay a member of our plan, please contact us.

Please remember that if you don't have or get Medicare prescription drug coverage or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

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

Thank you.

Exhibit 26: Acknowledgement of Request to Cancel Disenrollment

Dear <name of member>:

As requested, we have cancelled your disenrollment with <plan name>. *[If PCP not applicable, omit following sentence. Terms such as “physicians” or “doctors” or “providers” may be used instead of “primary care physician”:]* You should keep using your <plan name> primary care physician for your health care.] Thank you for your continued membership in <plan name>.

IMPORTANT: If you have also enrolled in another Medicare Advantage plan or Medicare Cost plan or Medicare Prescription Drug Plan, you may appear on their records as being enrolled. If you want to stay enrolled in <plan name>, you will need to notify the other Medicare plan 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 name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 27: MA Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in MA-PD Plan

[Member #]
[RxID]
[RxGroup]
[RxBin]
[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. *[Insert for those with retroactive effective dates: To make sure that you don't lose a day of your drug coverage,]* *[Insert for those with prospective effective dates: To make sure you have prescription drug coverage,]* Medicare has asked us to enroll you in our <MA-PD plan name> that includes Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

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 name> doctor(s). You will need to pay our copayments when you get health care. *[Optional: This letter is proof of insurance that you should show during your doctor appointments.]* *[Optional: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]*

What are my costs in this plan?

With this Medicare prescription drug coverage, you will pay no more than:

- \$0 for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by the plan.

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

[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.]

What do I need to know about getting health care services?

[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 name> doctor without prior authorization, you will have to pay for the health care yourself.]

[MA PPO plans use the following paragraph: Beginning <effective date>, you will get 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.]

[MA PFFS plans use the following paragraph: Beginning <effective date>, you will begin to receive your healthcare from <new plan name>, 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. <new plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital doesn’t have to agree to accept the plan’s terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan’s terms and conditions on our website at <insert link to PFFS terms and conditions>.]

What if Medicaid used to pay for my prescription drugs?

Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few 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 <new plan name>.

What if I have other prescription drug coverage?

If you now have drug coverage through an employer or union plan, joining a Medicare drug plan may NOT be right for you. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family current coverage. You may not need to join a Medicare drug plan. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy.

What if I want to join another plan?

You aren’t required to be in our Medicare prescription drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare prescription drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

What if I don’t want Medicare prescription drug coverage?

If you don’t want Medicare prescription drug coverage at all, call <plan name> at <phone number> within 10 days of the date on this letter. 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 27a: MA-PFFS Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP

[Member #]

[RxID]

[RxGroup]

[RxBin]

[RxPCN]

Dear <insert member name>

Our records show that you have Medicare and Medicaid. To make sure you have prescription drug coverage. Medicare has asked us to enroll you in our <PDP name> that provides Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

How does this plan work?

Starting <effective date>, all of your health care will continue to be covered under your <current MA-only plan name> and your prescription drug coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan> won't change. **[Optional:** You will be sent a membership card along with more detailed information about your prescription drug coverage in the next several days. Until you get your prescription drug card, you can use this letter to buy your prescriptions.]

With the addition of this Medicare prescription drug coverage, you will pay no more than:

- \$0 for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by the plan.

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

There will be no changes to your premium, medical benefits or member copayments under the <current MA-only plan name>.

What if Medicaid used to pay for my prescription drugs?

Remember, Medicaid won't pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few 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 <PDP name>.

What if I have other prescription drug coverage?

If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug**

coverage completely and not get it back if you join <plan name>. Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I paid for drugs before my new coverage starts?

If you filled any covered prescriptions before <effective date>, you might be able to get back part of what the prescriptions cost if you were eligible for Medicare and Medicaid but not enrolled in a Medicare drug plan. Call Medicare's Limited Income NET program at 1-800-783-1307. TTY users should call 711. You can also visit <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET>.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?

You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> within 10 days of the date on this letter. 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 into MA-PD plan

[Member #]

[RxID]

[RxGroup]

[RxBin]

[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs. Medicare has asked us to enroll you in our <MA-PD plan name> that offers Medicare prescription drug coverage beginning <effective date>, unless you tell us you don't want to join our plan.

[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 <MA-PD plan name> doctor(s). You will need to pay our copayments when you get health care.]

[Optional: This letter is proof of insurance that you should show during your doctor's appointments until you get your member card from us.] [Optional: This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.]

What are my costs in this plan?

With Medicare prescription drug coverage, you will pay no more than:

- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by our plan.

[Include cost of premium less amount of premium assistance for which the member is eligible, 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.]

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

What do I need to know about getting health care services?

[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-<MA-PD plan name> doctor without prior authorization, you will have to pay for the health care yourself.]

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

[MA PPO plans use the following paragraph: Beginning <effective date>, you will get 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.]

[MA PFFS plans use the following paragraph: Beginning <effective date>, you will begin to receive your healthcare from <new plan name>, 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. <MA-PFFS plan name>, a Medicare Advantage Private Fee-for-Service Plan, works differently than Original Medicare. Your doctor or hospital isn’t required to agree to accept the plan’s terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before each visit. Providers can find the plan’s terms and conditions on our website at <insert link to PFFS terms and conditions>.

What if I have other prescription drug coverage?

If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family’s current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I want to join another plan, or I don’t want Medicare prescription drug coverage?

You aren’t required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don’t want Medicare prescription drug coverage at all, call <plan name> at <phone number> before <effective date>. 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 28a: MA Model Notice to Inform Member of Facilitated Enrollment into PDP

[Member #]

[RxID]

[RxGroup]

[RxBin]

[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs . To make sure you have prescription drug coverage, Medicare has asked us to enroll you in our <name of PDP> that provides Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

Starting <effective date>, all of your health care, will continue to be covered under your <current MA-only plan name>, and your pharmacy coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan name> won't change. [Optional: You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]

With the addition of this Medicare prescription drug coverage, you will pay no more than:

- <insert appropriate LIS copay amount> copayments when you fill a prescription covered by our plan.

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

There will be no changes to your premium, medical benefits or member copayments under <current MA-only plan name>.

What if I have other prescription drug coverage?

If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join <plan name>.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

What if I paid for drugs before my new coverage starts?

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

If you filled any covered prescriptions before <effective date>, you might be able to get back part of what the prescriptions cost if you were eligible for Medicare and Medicaid but not enrolled in a Medicare drug plan. Call Medicare's Limited Income NET program at 1-800-783-1307. TTY users should call 711. You can also visit <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET>.

What if I want to join another plan, or I don't want Medicare prescription drug coverage?

You aren't required to be in our Medicare drug plan and can stay in <name of MA-only plan>. You can also decide to join a different Medicare drug plan. Call 1-800-MEDICARE anytime, 24 hours a day, 7 days a week for help in learning how. TTY users should call 1-877-486-2048.

If you don't want Medicare prescription drug coverage at all, call <plan name> at <phone number> before <effective date>. 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 Opt Out of Auto/Facilitated Enrollment

Dear <name of member>:

As requested, we have processed your request to decline (opt out of) Medicare prescription drug coverage. You will continue to be a member of <plan name> that doesn't offer Medicare prescription drug coverage.

If you have Medicaid drug coverage, it won't pay for your prescription drugs.

Remember, even if you don't use a lot of prescription drugs now, you still should consider joining a Medicare prescription drug plan. As we age, most people need prescription drugs to stay healthy.

From October 15 through December 7, you can join, switch or drop a Medicare health or drug plan for the following year. You can join, switch or leave a plan at other times while you qualify for (or lose) Extra Help paying for prescription drug costs.

If you change your mind and would like to join, you can call <plan name> at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 30: Model Notice for Enrollment Status Update

(For use with Transaction Reply Codes (TRC) from User Interface (UI) changes)

[Member #]

Dear <Name of Member>:

Your enrollment in <Name of Plan> has been updated.

[Insert one or more of the following, including sufficient detail to describe the specific enrollment change:]

- You have been enrolled in <name of plan>. Your coverage will start on <insert start date> and will end on <insert end date>. *[Insert information about premiums, if applicable, and how to access coverage, etc.]*.
- Your enrollment in <name of plan/old PBP> has been changed to <name of plan/new PBP>. Your coverage in <name of plan/new PBP> will start on <date>. *[Insert information on premium differences (if any), cost sharing information, and other details the individual will need to ensure past and future coverage is clear]*
- Your enrollment in <Name of Plan> has been changed to start on an earlier date. Your coverage will start <date>. *[Include information about premiums, coverage, and how to get refunded for prescriptions purchased in the period of retroactive coverage.]*
- Your enrollment in <Name of Plan> has been changed to start on a later date. Your coverage with <Name of Plan> will start on <date>. *[Insert information about refunding premium, where applicable, and impact to paid claims]*
- Your enrollment in <Name of Plan> *[ended, will end]* on <date>. This means you *[don't, won't]* have coverage from <Name of Plan> after <date>. *[Insert appropriate descriptive information, such as premium owed if the date has moved forward, or premium refunds if the date has moved back, and impact on paid claims or how to submit claims, as applicable]*
- Your enrollment in <Name of Plan> has been cancelled. This means that you don't have coverage from <Name of Plan>. *[Insert information about refund of premium, if applicable, and impact to any paid claims]*

[Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary]

[Insert if enrolling in a PFFS plan: <Name of Plan>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital isn't required to agree to accept the plan's terms and conditions, and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept <Plan name> before

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

each visit. Providers can find the plan’s terms and conditions on our website at <insert link to PFFS terms and conditions>.]

[Dual-eligible SNPs may omit the following paragraph:]

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won’t have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don’t even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.ssa.gov/medicare/part-d-extra-help.

Call <toll-free number> <days and hours of operation> to get more information. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 31: Model Employer/Union Sponsored MA Plan Group Enrollment Mechanism Notice

Dear <name>

<Name of Employer/Union> is enrolling you in <plan name> as your retiree health benefit plan beginning <effective date>, unless you tell us by <insert date no less than 21 days from date of notice> that you don't want to join our plan. <Plan name> is a Medicare Advantage plan. This enrollment will automatically cancel your enrollment in a different Medicare Advantage plan or a Medicare Prescription Drug (Part D) plan. Please call us if you think you might be enrolled in a different Medicare Advantage plan or a Medicare Prescription Drug plan.

What do I need to know as a member of <plan name>?

This mailing includes important information about this plan and the coverage it offers, including a summary of benefits document. Please review this information carefully. If you want to be enrolled in this Medicare health plan, you don't have to do anything, and your enrollment will automatically begin on <effective date>.

Once you are a member of <Plan Name>, you have the right to appeal plan decisions about payment or services if you disagree. Read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when you get it to know which rules you must follow to get coverage with this Medicare Advantage Plan. Enrollment in this plan is generally for the entire year.

[MA PFFS do not include the following paragraph: Beginning on the date <plan name> coverage begins, you must get all of your health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR SERVICES.**]

You will need to keep Medicare Parts A and B as <Plan Name> is a Medicare Advantage Plan. You can be in only one Medicare Advantage Plan at a time. It is your responsibility to inform <Plan Name> of any prescription drug coverage that you have or may get in the future.

By joining this Medicare health plan, you acknowledge that the Medicare health plan will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <plan name> will release your information [**MA-PD plans insert:** including your prescription drug purchase history] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

What happens if I don't join <plan name>?

You aren't required to be enrolled in this plan. <insert information about other group sponsored plan options, if there are any>. You can also decide to join a different Medicare plan. Call 1-800-MEDICARE for help in learning how. However, if you decide not to be enrolled <insert consequences for opting out of group plan, like that you cannot return, or that other benefits are

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

impacted>. To request not to be enrolled by this process <insert clear instruction for opting out including telephone numbers and times of operation where those numbers will be answered>.

What if I want to leave <Plan Name>?

You may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Plan Name>.

<Plan Name> serves a specific service area. If you move out of the area that <Plan Name> serves, you need to notify the plan so you can disenroll and find a new plan in your new area.

[MA-only plans insert the following, unless the employer/union provides other creditable coverage: Remember that if you leave this plan and don't have creditable prescription drug coverage (as good as Medicare's prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

Thank you.

Attachment

Exhibit 32: Model Notice for Loss of Special Needs Status

Dear <Name of Member>:

<Insert plan or organization name> must disenroll a member from <Insert plan name> if a member doesn't <describe special needs status> and doesn't reestablish <describe required special needs status> prior to the expiration <insert length of period of deemed continued eligibility>.

Why am I receiving this notice?

Our records indicate that you no longer <describe special needs status that individual has lost>. To be a member of <plan name>, you must <describe required special needs status>.

How long will I continue to receive coverage?

<Plan name> will continue to cover your Medicare benefits until <insert end date for period of deemed continued eligibility>. You have <insert length of period of deemed continued eligibility> to re-qualify for our plan.

When will coverage end?

If, at the end of <insert length of period of deemed continued eligibility>, you haven't <describe special needs criteria that must be met> and you haven't enrolled in a different plan, we will disenroll you and you will be covered by Original Medicare beginning <insert end date for period of deemed continued eligibility>.

What do I do if my coverage ends?

When coverage from <plan name> ends, your Medicare prescription drug coverage ends too. To have new health care coverage and prescription drug coverage after <date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. For example, if you are returning to Original Medicare coverage, to get Medicare prescription drug coverage you must join a Medicare prescription drug plan. Please remember, if you disenroll from <plan name> and don't have or get other creditable prescription drug coverage (as good as Medicare prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

When can I join another plan?

Because you are no longer eligible for our plan, Medicare will give you a special one-time opportunity to change to a different Medicare Advantage Plan or Medicare Prescription Drug Plan. This opportunity begins now and ends when you enroll in a different plan or on <insert date three months after the expiration of the period of deemed continued eligibility>, whichever is earlier. If you don't take any action, <plan name> will continue to cover your Medicare benefits until <insert end date for period of deemed continued eligibility>.

Once you use the special one-time opportunity to change plans, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31**, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following paragraph:]

What is extra help?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

What if I don't agree with this decision or if I have questions?

If this information is wrong and you continue to be eligible for <plan name> or if you believe you have already re-qualified for our plan and you want to stay a member of our plan, please contact us immediately at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 33: Model Notice for Loss of SNP Status - Notification of Involuntary Disenrollment

Dear <Name of Member>:

On <date> we sent you a letter that said you no longer *<describe special needs status that individual has lost>*. The letter said that if you didn't *<describe special needs criteria that must be met>*, we would disenroll you and you would be covered by Original Medicare beginning *<insert end date for period of deemed continued eligibility>*.

Why am I receiving this notice?

According to our records, you remain ineligible for <plan name>. Therefore, we asked Medicare to disenroll you from <plan name> beginning <date>.

What if I don't agree with this decision?

You have the right to ask us to reconsider this decision through the grievance process described in your *[insert "Member Handbook" or "Evidence of Coverage", as appropriate]*.

What happens next?

Due to your disenrollment from <plan name>, you will be covered by Original Medicare, beginning <effective date> unless you take action.

When can I join another plan?

As described in our earlier letter, you have a special one-time opportunity to enroll in a different Medicare Advantage Plan or Medicare Prescription Drug Plan. This opportunity will end when you enroll in a different plan or on *<insert date three months after the expiration of the period of deemed continued eligibility>*, whichever is earlier.

Once you use the special one-time opportunity to change plans, there are limits to when and how often you can change the way you get Medicare:

- **From October 15 through December 7**, anyone with Medicare can switch plans or return to Original Medicare. This includes adding or dropping Medicare prescription drug coverage for the following year.
- **From January 1 through March 31**, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[Dual-eligible SNPs may omit the following two paragraphs:]

What is extra help?

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

Why is it important to find new drug coverage?

Please remember, if you don't enroll in another Medicare Advantage Plan with prescription drug coverage or a Medicare Prescription Drug Plan or other creditable prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Information About Medigap Rights

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 Medigap rights in your State, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number>. You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for more information. TTY users should call 1-877-486-2048.

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

Thank you.

Exhibit 34: MA Model Notice to Research Potential Out of Area Status

<Date>

<Member ID>

Dear <member name>:

We have recently received information that your address may have changed and that you may not live in the service area of <plan name>. **If you don't contact us to verify your address, you will be disenrolled from <plan name> effective <disenrollment effective date>.**

It is important that you contact us to verify your permanent address. You may use this form and return it to us in the enclosed envelope or you may call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Please note that your permanent address must be inside our service area in order for you to be a member of <plan name>. You may request that we send mail to you at another address outside of our service area. You may also temporarily reside for up to *[insert either "six" or the length of the plan's visitor traveler program (if any)]* months outside our service area and remain a member of <plan name>. But if you permanently move outside our service area or if you temporarily live outside our service area for more than six months in a row, we must disenroll you from <plan name>. You will have an opportunity to enroll in a plan that serves the area where you now live.

Your Permanent Address

Please tell us the permanent address where you live. Do not use a post office box.

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number: _____

Your Temporary Address

If you are currently living somewhere other than your permanent address, please provide the address. Do not use a post office box. (You may skip this section if you are living at your permanent address.)

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number: _____
When did you begin living at this address? _____
When do you expect to return to your permanent address? _____

Your Mailing Address

If the address that you want us to use to send information to you is different than your permanent address, please provide it below. (You may skip this section if your mailing address is the same as your permanent address that you provided.)

Street or P.O. Box: _____

City, State, ZIP: _____

County: _____

If you have moved and have not notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

If you have any questions or need help, please call us at <customer service phone number>.

Thank you.

Exhibit 35: MA Model Notice for Disenrollment Due to Out of Area Status (No Response to Request for Address Verification)

<Date>

<Member ID>

Dear <member name>:

On <date of notice requesting address verification> we asked you to contact us so that we could determine whether you had moved out of the [*Optional: Parent Organization Name*] <plan name> service area. As we explained in our earlier letter, in order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to [*insert either “six” or the length of the plan’s visitor traveler program (if any)*] consecutive months.

Our records show that you have not responded to our earlier letter. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.**

Beginning <effective date>, <plan name> won’t cover any health care you get. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans add the following:* When your coverage from <plan name> ends, your Medicare prescription drug coverage ends too. Beginning <effective date>, <plan name> also won’t cover any prescriptions you get. You won’t have any prescription drug coverage beginning <effective date> unless you have enrolled in another prescription drug plan.]

What if I disagree with this decision?

You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?

You may have up to two months to join a new Medicare Advantage Plan or a Medicare prescription drug plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

What if I don’t enroll in a new plan right now?

If you don’t enroll in a Medicare Advantage Plan during this special two-month period, you may have to wait to enroll in a new plan. You can join or change health plans only at certain times during the year. From October 15 – December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can’t make changes at other times except in certain situations, such as you want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help paying for prescription drug costs.

[MA-PD plans insert: What happens if I don't enroll in another Medicare Prescription Drug Plan?

Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

What if my premium was being deducted from my Social Security benefit check?

If your plan premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

[Dual-eligible SNPs may omit the following paragraph:]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

What should I do if I've moved?

If you have moved and haven't notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?

If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 36: MA Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)

<Date>

<Member ID>

Dear <member name>:

Thank you for informing us of your recent change of permanent address. Your permanent address is now outside the <plan name> service area. In order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to [*insert either “six” or the length of the plan’s visitor traveler program (if any)*] consecutive months. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.**

Beginning <effective date>, <plan name> won’t cover any health care you receive. Beginning <effective date>, you can see any doctor through Original Medicare, unless you have enrolled in another Medicare Advantage plan.

[*MA-PD plans add the following:* When your coverage from <plan name> ends, your Medicare prescription drug coverage ends too. Beginning <effective date>, <plan name> also won’t cover any prescriptions you get. To have new prescription drug coverage after <date>, you need to join a new Medicare Advantage plan with prescription drug coverage or join a Medicare prescription drug plan.]

What if I disagree with this decision?

You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

Can I enroll in a new plan?

You may have up to two months to join a new Medicare Advantage Plan or Medicare prescription drug plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) for information about plans that may serve your area.

What if I don’t enroll in a new plan right now?

If you don’t enroll in a Medicare Advantage Plan during this special two-month period, you may have to wait to enroll in a new plan. You can join or change health plans only at certain times during the year. From October 15 – December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally you can’t make changes at other times except in certain situations, such as you want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help paying for prescription drug costs.

[MA-PD plans insert: What happens if I don’t enroll in another Medicare Prescription Drug Plan?

Please remember, if you don’t enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don’t have or obtain other coverage that

is at least as good as Medicare drug coverage (also referred to as “creditable coverage”), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

What if my premium was being deducted from my Social Security benefit check?

If your plan premium is being deducted from your Social Security benefit, please allow up to 3 months for us to process a refund. If you haven’t received a refund from Social Security within 3 months of this letter, you should contact 1-800-MEDICARE.

[Dual-eligible SNPs may omit the following paragraph:]

Can I get help paying my premiums and other out-of-pocket costs?

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won’t have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don’t even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

What should I do if I’ve moved?

If you have moved and haven’t notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

What should I do if I have more questions?

If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

Exhibit 37: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration

<Date>

Dear <Beneficiary Name>:

Medicare has disenrolled you from <plan name> because its records show that you are incarcerated. As of <effective date>, you no longer have coverage through <plan name>. [MA-PD plans insert: Your Medicare prescription drug coverage ended on the same date.] You will have Original Medicare; however, Medicare generally doesn't pay for your hospital or medical bills if you're incarcerated. If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, based on information from SSA, not by <plan name>.

What if I think there's been a mistake?

If you aren't incarcerated or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

What happens to my Medicare and Part D coverage?

While you are incarcerated, you are not eligible to enroll in a Medicare health or Part D plan. However, once you are released and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. *This opportunity begins the month you are released and lasts for two additional months.* If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after your release, you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

Who can I call to get more information?

You can call Social Security at 1-800-772-1213, if you have questions about your incarcerated status. TTY users should call 1-800-325-0778. If you have questions about your Medicare coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also call <plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

Exhibit 38: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence

<Date>

Dear <member name>:

Medicare has disenrolled you from <plan name> because the Social Security Administration (SSA) reported that you are not lawfully present in the United States. As of <effective date>, you no longer have coverage through <plan name>. [MA-PD insert: Your Medicare prescription drug coverage ends on this date.] You will have Original Medicare; however, Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S.

If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, based on information from SSA, not by <plan name>.

What if I think there's been a mistake?

If you aren't unlawfully present in the U.S. or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

What happens to my Medicare and Part D coverage?

While you are unlawfully present in the United States, you are not eligible to receive any coverage in the Medicare program. This includes coverage through Original Medicare, a Medicare health plan or Medicare prescription drug coverage.

If you become lawfully present in the U.S. in the future and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. This opportunity begins the month you regain lawful presence status and lasts for two additional months. If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after you become lawfully present in the U.S., you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

Who can I call to get more information?

You can call Social Security at 1-800-772-1213, if you have questions about your lawful presence status. TTY users should call 1-800-325-0778. If you have questions about your

<Contract#, alpha-numeric identifier, "CMS Approved/File & Use" [date] (as applicable)>

Medicare coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.