PDP Guidance

Eligibility, Enrollment and Disenrollment

Update: June 20, 2007

This guidance update represents final CMS policy and is effective for contract year 2008, including all enrollments with an effective date on or after January 1, 2008. Please note that Special Election Period (SEP) expansions (such as the expanded SEP for low-income subsidy individuals) are effective immediately upon release of this new guidance. Additionally, sponsors should ensure that their notices to confirm auto and facilitated enrollment contain the important updates regarding possible reimbursement of drug costs during retroactively enrolled periods, and the impact of their Part D enrollment on other existing prescription drug coverage. Organizations may implement other aspects of this guidance before the required implementation date.

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Important Note:

Instructions provided in this guidance apply to Medicare Prescription Drug Plans (PDPs). Guidance for eligibility, enrollment and disenrollment procedures for Medicare Advantage (MA) plans *is established in the MA Enrollment and Disenrollment Guidance (*Chapter 2 of the Medicare Managed Care Manual*)*.

10 - Eligibility and Enrollment in a Part D Plan

In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and/or Part B as of the effective date of coverage under the plan; and

2. The individual permanently resides in the service area of a PDP.

An individual who is living abroad or is incarcerated is not eligible for Part D as he or she cannot meet the requirement of permanently residing in the service area of a Part D plan.

A PDP sponsor may not impose any additional eligibility requirements as a condition of enrollment other than those permitted by CMS.

For those not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B or those not eligible for Part D during first Medicare initial enrollment period for Part D that occurred from November 15, 2005 through May 15, 2006, their initial enrollment period is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D. For individuals whose Medicare entitlement determination is made retroactively, Part D eligibility begins with the month the individual receives the notice of the Medicare entitlement determination*, as described in §201*.

Individuals may *only request* enroll*ment* in a PDP during an enrollment period, as described in §20. A PDP sponsor can not deny a valid enrollment request from any Part D eligible individual residing in its service area, except as provided in this guidance. Individuals enrolling in a Medicare Advantage Prescription Drug (MA-PD) plan are subject to the procedures provided in the *MA Enrollment and Disenrollment Guidance (MMCM*, Chapter 2*)*.

Individuals in a cost-based HMO/CMP have the option to enroll in a standalone PDP, regardless *of* whether Part D is offered as an optional supplemental benefit by the cost plan. Individuals enrolling in a Part D plan that is offered as an optional supplemental benefit in a Cost-based HMO/CMP plan must do so according to the requirements for

enrollment in a PDP contained in this guidance. Such an individual must be a cost plan member to enroll in the cost plan's optional supplemental Part D benefit.

A PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. *However, if an individual enrolls in a PDP and continues to enroll in an employer/union plan for which the retiree drug subsidy (RDS) is claimed, the retiree drug subsidy will terminate, at which point* coordination of benefits (COB) rules will apply.

A Part D eligible individual may not be enrolled in more than one Part D plan at the same time. A Part D eligible individual may not be simultaneously enrolled in a PDP and a Medicare Advantage (MA) plan except for a MA Private Fee-For-Service (PFFS) plan that does not offer the Part D benefit, a Medicare Medical Savings Account (MSA), or unless otherwise provided under CMS waiver authority.

The PFFS exception is applied at the plan level (i.e. PBP). An individual enrolled in an MA PFFS plan (also know as "plan benefit package, or PBP) that does not offer Part D may enroll in a stand-alone PDP, even if the same MA organization offers other plans (including PFFS plans) that include a prescription drug benefit.

10.1 - Entitlement to Medicare Parts A and/or B

To be eligible for Part D and to enroll in a PDP, an individual must be entitled to Medicare Part A or enrolled in Part B as of the effective date of coverage under the PDP.*§30.2 provides information on verification of Medicare entitlement.*

10.2 - Place of Permanent Residence

An individual is eligible for Part D and able to enroll in a PDP if he/she permanently resides in the service area (region) of the PDP. A temporary stay in the PDP's service area does not enable the individual to enroll. An individual who is living abroad or is incarcerated does not meet the requirement of permanently residing in the service area of a Part D plan (even if the correctional facility is located within the plan service area).

A permanent residence is normally the primary residence of an individual. Generally, permanent residence is established by the address provided by the individual, but a PDP sponsor- may request additional information such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, or utility bills if there is a question. Such records must establish the permanent residence address, and not the mailing address, of the individual. If an individual puts a Post Office Box as his/her place of residence on the enrollment request, the PDP sponsor must contact the individual to confirm that the individual lives in the service area. If there is a dispute over where the individual permanently resides, the PDP sponsor should determine whether, according to the law of the State, the person would be considered a resident of that State.

In the case of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail (e.g., social security checks) may be considered the place of permanent residence.

10.3 - Completion of Enrollment Request

Unless otherwise specified by CMS, an eligible individual enrolls in a PDP by completing and submitting an enrollment request to the PDP organization, providing all of the required information to complete enrollment within required time frames. Enrollment request formats include paper enrollment forms and other mechanisms approved by CMS and offered by the PDP organization. The model enrollment form is provided in **Exhibit 1**.

Except as permitted by CMS for individuals enrolling in a PDP by other means, a PDP sponsor must deny enrollment to any individual who does not properly complete an enrollment request within required time frames. Procedures for completing enrollment requests are provided in §30.2.

10.4 – Other Coverage Through an Employer/Union *Group*

CMS systems will compare Part D enrollment transactions to information regarding the existence of *e*mployer or *u*nion coverage for which the beneficiary is also being claimed for the *Retiree Drug Subsidy (RDS)*. If there is a match indicating that the individual may have such other coverage, the enrollment will be conditionally rejected by CMS systems *with a transaction reply code (TRC) 127 (see CMS' Plan Communications User Guide for information on TRCs)* .

*Within 10 calendar days of receipt of the Code 127 conditional rejection, t*he PDP sponsor must contact the individual to confirm the individual's intent to enroll in Part D (see **Exhibit 5**), and that the individual understands the implications of enrollment in a Part D plan on his or her employer/union coverage. The individual will have 30 calendar days from the date he or she is contacted or notified to respond. The PDP sponsor *may contact the individual in writing (see **Exhibit 5**) or by phone and* must document this contact and retain it with the record of the individual's enrollment request. If the individual indicates that s/he is fully aware of any consequence to his/her employer/union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the PDP sponsor must update the transaction with the appropriate "flag" (detailed instructions for this activity are included with CMS systems guidance) and re-submit it for enrollment. The effective date of enrollment will be based *on the receipt of* the beneficiary's initial enrollment request not when the individual confirms that s/he wants to enroll. This effective date may be retroactive in the event that the confirmation step occurs after the effective date.

PDP sponsors are encouraged to closely monitor their outreach efforts and to follow up with applicants prior to expiration of the 30 day timeframe. If the individual does not respond in 30 days, the enrollment must be denied because the individual failed to

provide the additional information requested. A denial notice must be provided (see Exhibit 6).

When an employer or union group sponsored PDP is replacing an existing RDS plan offered by that employer or union group, the PDP sponsor may receive the Code 127 conditional rejection. In these cases it is not necessary to contact each individual, as described above. The PDP sponsor must resubmit the transactions updated with the appropriate flag.

PDP sponsors should work in close collaboration with employer/union sponsors who are replacing RDS coverage with Part D coverage to ensure that all individuals are aware of the change and have the information they need.

20 – Enrollment and Disenrollment Periods and Effective Dates

In order for a PDP sponsor to accept an enrollment or disenrollment request, a valid request must be made during an available enrollment period. It is the responsibility of the PDP sponsor to determine the enrollment period of each enrollment request. There are 3 periods in which an individual may enroll in and/or disenroll from a PDP:

- The Initial Enrollment Period for Part D (IEP for Part D);
- The Annual Coordinated Election Period (AEP);
- All Special Enrollment Periods (SEP).

During the AEP and SEP, individuals may enroll in and disenroll from a PDP plan, or choose another PDP plan. Individuals may enroll in a PDP during the IEP for Part D. Each individual has one election per enrollment period; once an enrollment or disenrollment becomes effective, the election has been used.

All PDP sponsors must accept enrollments into their PDP plans during the AEP, an IEP for Part D, and an SEP. PDP enrollment periods coordinate with similar periods in Medicare Advantage (MA) to accommodate enrollment in MA plans with a Part D benefit (MA-PD plans).

The last enrollment or disenrollment choice made during an enrollment period, determined by the date a request was received by the PDP sponsor, will be the choice that becomes effective. As outlined in CMS' systems guidance for PDP sponsors (and MA organizations), the enrollment transaction will include this information (the "application date").

20.1 – Initial Enrollment Period for Part D (IEP for Part D)

The initial enrollment period is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when an individual is entitled to Part A OR enrolled in Part B, AND lives in the service area of a Part D plan.

At the beginning of the Part D program, there was an IEP for Part D for all current Medicare beneficiaries and individuals who became eligible for Medicare in January 2006 that began on November 15, 2005 and ended May 15, 2006.

Individuals who are becoming eligible for Medicare will have an Initial Enrollment Period for Part D that is the 7 month period surrounding Medicare eligibility (same as the IEP for Part B). The IEP for Part B is the 7-month period that begins 3 months before the month an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility. See 42 CFR §407.14.

For those not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B or those not eligible for Part D during *the* first Medicare initial enrollment period for Part D that occurred from November 15, 2005 through May 15, 2006, their initial enrollment period *for Part D* is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D.

Individuals eligible for Medicare prior to age 65 (such as for disability) will have another Initial Enrollment Period for Part D based upon attaining age 65.

If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to enroll in a PDP during his/her IEP for Part D. Therefore, the IEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for three additional months after the month the notice is provided. The effective date is generally the first day of the month after the PDP sponsor receives a completed enrollment request.

Example 1 -- IEP for Part D surrounding 65th birthday:

Mrs. Smith's 65th birthday is April 20, 2006. She is eligible for Medicare Part A and her Part B initial enrollment period begins on January 1, 2006. Therefore, her IEP for Part D begins on January 1, 2006 and ends on July 31, 2006.

Example 2 -- IEP for working individual:

Mr. Hackerman's 65th birthday is March 23, 2006. He is currently working, and while he signed up for his Medicare Part A benefits, effective March 1, 2006, he declined his enrollment in Part B, given his working status. He is eligible for Part D since he has Part A and lives in the service area. Even though he did not enroll in Part B, his Part B IEP is still the 3 months before, the month of, and the 3 months following his 65th birthday – that is, December 2005 – June 2006. Hence, his IEP for Part D is also December 2005 – June 2006.

Example 3 -- IEP exception for Part D*:*

Mr. Duke lived in Italy at the time of his 65th birthday, which occurred on August 3, 2006. His Part B initial enrollment period began on May 1, 2006 and ended November 30, 2006. He plans to return to the U.S. to reside permanently in June 2007. Since he lived out of the U.S. and was not eligible to enroll in a Part D plan during his IEP for Part B, his initial enrollment period for Part D will occur when he meets all the eligibility requirements for Part D, that is, when he has Part A or B and lives in a plan service area. His IEP for Part D is March 2007 – September 2007.

Example 4 -- IEP for retroactive Medicare determination:

Mr. Schlosser received notification of his Medicare determination June 15, 2007. He was informed in this notice that Medicare Part A will be effective as of July 1, 2007. Therefore, his Part D initial enrollment period begins in June 2007 and ends September 30, 2007.

Once an individual uses his/her IEP for Part D enrollment and this enrollment becomes effective, this enrollment period ends. Refer to the table in §20.4 of this guidance for effective date information.

20.2 – Annual Coordinated Election Period (AEP)

The AEP occurs November 15 through December 31 of every year.

There is one AEP enrollment/disenrollment choice available for use during this period. Once the enrollment/disenrollment is effective, the individual has exhausted this choice.

Refer to §20.4 and 20.5 for effective date information.

20.3 - Special Enrollment Periods - (SEP)

During an SEP, an individual may discontinue enrollment in a PDP offered by a PDP sponsor, change to a different Part D plan, or in certain cases specified below, enroll in a Part D plan. *Certain SEPs may be limited to an enrollment or disenrollment request.* If

the individual disenrolls from (or is disenrolled from) the PDP, the individual may subsequently enroll in a new Part D plan within the SEP time period. Once the individual has enrolled in a new Part D plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the SEP ends when the individual enrolls in a new Part D plan or when the SEP time frame ends, whichever comes first, unless specified otherwise for an SEP.**

It is the responsibility of the PDP sponsor to determine whether the individual is eligible for the SEP. To make this determination, the PDP sponsor must contact the individual to obtain this information. Unless otherwise required in this guidance, the PDP sponsor MUST accept verbal confirmation from the individual regarding the conditions that make him or her eligible for the SEP. The sponsor may obtain this information at the time of the enrollment request (see optional Exhibit 1a)

The following questions are examples of questions that might be used to determine eligibility for an SEP:

Type of SEP?	Examples of Questions
Change in Residence	Have you recently moved? If so, when? Where did you move from?
Employer*/Union* Group Health Plan	Do you currently have (or are leaving) coverage offered by an employer or union? Have you recently lost such coverage?
Disenroll from Part D to enroll in Creditable Coverage	Are you a member of TriCare? Do you want to obtain VA benefits?
Dual Eligible	Do you currently have Medicaid coverage? Does your state pay for your Medicare premiums? Did you recently receive a yellow letter from Medicare (for full duals)? Have you recently lost coverage under Medicaid?
Other Low Income Subsidy	*Do you receive* extra help? *Have you recently received a green letter from Medicare?* Did you receive a letter from Medicare letting you know that you automatically

	qualify for extra help? *Do you receive SSI cash benefits without Medicaid?*
Institutionalized	Are you moving into or are you a current resident of an institution, such as a nursing facility or long-term care hospital? Are you moving out of such a facility?
MA "open enrollment period"	If during January – March: Were you recently a member of a Medicare Advantage plan which included Medicare prescription drug coverage?
PACE	For enrollment – are you currently enrolled in a special plan called "PACE"?

If the contact is made orally (by phone), the PDP sponsor must document the contact and retain the documentation in its records. If the PDP sponsor requests this confirmation through a written notice, such notice must include the option (and information) needed to call the PDP sponsor and confirm this information verbally. The PDP sponsor must obtain this confirmation in accordance with Section 30.2.2 . If the PDP sponsor is not able to obtain this confirmation, the sponsor must provide the individual with a notice of denial of enrollment (see **Exhibit 6**).

Please note that the time frame of an SEP denotes the time frame during which an individual may make an enrollment or disenrollment request. It does not necessarily correspond to the effective date of the actual enrollment or disenrollment. For example, if an SEP exists for an individual from May through July, then a PDP sponsor must receive an enrollment or disenrollment request from that individual some time between May 1 and July 31 in order to consider the request to have been made during the SEP. However, the type of SEP will dictate the effective date of coverage, and that effective date of coverage can occur after July 31. The following discussion of SEPs and their corresponding effective dates will demonstrate this concept more fully.

20.3.1 - SEPs for Changes in Residence

An SEP for changes in residence exists for these scenarios:

1) individuals who are no longer eligible to be enrolled in a PDP due to a change in permanent residence outside of the PDP's service area;
2) individuals who were not eligible for Part D because they have been out of the U.S. and have now moved back to the U.S.;
3) individuals who were not eligible for Part D because they were incarcerated and have now been released;
4) individuals will have new Medicare health or Part D plans available to them as result of a permanent move.

The SEP may begin with either the actual date of the permanent move or with the date the individual provides notification of such move. It is the individual's responsibility to notify the PDP that he/she is permanently moving.

If the individual notifies the plan of a permanent move, the SEP begins the month prior to the month of the individual's permanent move and continues during the month of the move and up to two months after the move.

If the plan learns from CMS or U.S. Post Office (as described in §40.2.1) that the individual has been out of the service area for over six months and the plan has not been able to confirm otherwise with the individual, the SEP will begin at the beginning of the sixth month and continues through to the end of the eighth month.

For enrollments associated with permanent moves, the effective date is associated with the date the PDP sponsor receives the completed enrollment request. The individual may choose an effective date of up to three months after the month in which the PDP sponsor receives the enrollment request. However, the effective date may not be earlier than the date the individual moves to the new service area and the PDP sponsor receives the completed enrollment request.

EXAMPLES:

Example 1:
A beneficiary is a member of a PDP in Florida and intends to move to Arizona on June 18. An SEP exists for this beneficiary from May 1 through August 31.

A. If a PDP sponsor in Arizona receives a completed enrollment form from the beneficiary in May and since the individual is not moving to the new service area until June 18th, the beneficiary can choose an effective date of July 1, August 1, or September 1.

B. If the PDP sponsor receives the completed enrollment form from the beneficiary in June (the month of the move) the beneficiary can choose an effective date of July 1, August 1, or September 1.

C. If the PDP sponsor receives the completed enrollment form in July, the beneficiary can choose an effective date of August 1, September 1, or October 1.

Example 2:
A beneficiary resides in Florida and is currently in Original Medicare and not enrolled in a PDP. The individual intends to move to Maryland on August 3. An SEP exists for this beneficiary from July 1 through October 31.

At the time the individual enrolls in a PDP, the individual must provide the specific address where s/he will permanently reside upon moving into the service area, so that the PDP sponsor can determine that the individual meets the residency requirements for enrollment in the plan. Please keep in mind that an enrollee of a PDP who moves permanently out of the service area must be disenrolled from the plan, as described in Section 40.2.1 of this guidance.

Disenrollment from Previous PDP

Please keep in mind that a member of a PDP who moves permanently out of the service area must be disenrolled from the plan. A member of a PDP who resides out of the area for over six months must be disenrolled from the plan. CMS has established an SEP that allows an individual adequate time to choose a new PDP, given the fact that the individual will no longer be enrolled in the original PDP after the month of the move or after the sixth month (whichever is appropriate).

20.3.2 - SEP for Dual-eligible Individuals or Individuals Who Lose Their Dual-eligibility

There is an SEP for individuals who are entitled to Medicare Part A and/or Part B and receive any type of assistance from the Title XIX (Medicaid) program. This also includes individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (e.g. QMB, SLMB, etc). This SEP begins the month the individual becomes dually-eligible and exists as long as s/he receives Medicaid benefits. This SEP allows an individual to enroll in, or disenroll from, a Part D plan. The effective date of the individual's enrollment in their new plan *would be the first of the month following receipt of an enrollment request. However, as described in 30.1.4, the effective date for auto-enrollments may be retroactive*.

In addition, PDP eligible individuals no longer eligible for benefits under Title XIX benefits will have an SEP beginning with the month they lose eligibility plus two additional months to make an enrollment choice in another PDP*, an MA-PD, or to disenroll entirely from Part D*.

20.3.3 - SEPs for Contract Violation

In the event an individual is able to demonstrate to CMS that the PDP sponsor offering the PDP of which he/she is a member substantially violated a material provision of its contract under Part D in relation to the individual by, but not limited to:

- failure to provide the individual on a timely basis benefits available under the plan;
- failure to provide benefits in accordance with applicable quality standards; or
- the PDP sponsor (or its agent) materially misrepresented the PDP when marketing the PDP,

the individual may disenroll from the PDP and enroll in another Part D plan. The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately enrolls in a new Part D plan upon disenrollment from the original PDP.

We note that in some case-specific situations, CMS may process a retroactive disenrollment for these types of disenrollments. If the disenrollment is not retroactive, an SEP exists such that an individual may elect another Part D plan during the last month of enrollment in the PDP sponsor, for an effective date of the month after the month the new PDP sponsor receives the completed enrollment request.

EXAMPLE

On January 16, CMS determines, based on a member's allegations, that the PDP sponsor substantially violated a material provision of its contract. As a result, the member will be disenrolled from the PDP on January 31. An SEP exists for this beneficiary beginning January 16 and lasting until the end of January. The beneficiary promptly applies for a new Part D plan, and the new PDP sponsor receives a completed enrollment request on January 28 for a February 1 effective date.

If the individual in the above example did not enroll in another PDP on January 28th, s/he would have an additional 90 calendar days from the effective date of the disenrollment from the first PDP to elect another PDP. The individual may choose an effective date of enrollment in a new PDP beginning any of the three months after the month in which the PDP sponsor receives the completed enrollment request. However, the effective date may not be earlier than the date the PDP sponsor receives the completed enrollment request.

EXAMPLE

On January 16, CMS determines, based on a member's allegations that the PDP sponsor substantially violated a material provision of its contract. As a result, the member disenrolls from the PDP on January 31. A 90-day SEP continues to exist for the beneficiary from February 1 through April 30. In this example, a new PDP sponsor then receives a completed enrollment request from the individual on

April 15. The beneficiary may choose an effective date of May 1, June 1, or July 1.

If the disenrollment is retroactive, CMS will provide the beneficiary with the time frame for his/her SEP to enroll in another Part D plan. *Depending on the circumstance surrounding the contract violation, CMS may determine a retroactive enrollment into another plan is warranted.*

20.3.4 - SEPs for Non-renewals or Terminations

In general, SEPs are established to allow members affected by PDP non-renewals or terminations ample time to make a choice of another PDP. Effective dates during these SEPs are described below. CMS has the discretion to modify this SEP as necessary for any non-renewal or termination when the circumstances are unique and warrant a need for a modified SEP.

In particular:

- **Contract Non-renewals -** An SEP exists for members of a PDP that will be affected by a contract non-renewal that is effective January 1 of the contract year (see 42 CFR §423.507 for requirements for contract non-renewals). For this type of non-renewal, PDP sponsors are required to give notice to affected members at least 90 calendar days prior to the date of non-renewal (42 CFR §423.507(a)(2)(ii)). To coordinate with the notification time frames, the SEP begins October 1 and ends on December 31 of that year.

  During this SEP, a beneficiary may choose an effective date of November 1, December 1, or January 1; however, the effective date may not be earlier than the date the new PDP sponsor receives the completed enrollment request.

- **PDP Sponsor Termination of Contract and Terminations/Contract Modifications by Mutual Consent -** An SEP exists for members of a PDP who will be affected by a termination of contract by the PDP sponsor or a modification or termination of the contract by mutual consent (see 42 CFR §423.508 for contract requirements regarding terminations). For this type of termination or modification, PDP sponsors are required to give notice to affected members at least 60 calendar days prior to the proposed date of termination or modification. To coordinate with the notification time frames, the SEP begins two months before the proposed termination effective date, and ends one month after the month in which the termination occurs.

  Please note that if an individual does not enroll in another PDP before the termination effective date, he/she will be disenrolled on the effective date of the termination. However, the SEP will still be in effect for one month after the effective date of the termination should the individual wish to subsequently enroll in a PDP (for a prospective, not retroactive, effective date).

Beneficiaries affected by these types of terminations may request an effective date of the month after notice is given, or up to two months after the effective date of the termination. However, the effective date may not be earlier than the date the new PDP sponsor receives a completed enrollment request.

EXAMPLE

If a PDP sponsor contract terminates for cause on April 30, an SEP lasts from March 1 through May 31. In this scenario, a beneficiary could choose an effective date of April 1, May 1, or June 1 in a new PDP; however, the effective date may not be earlier than the date the new PDP sponsor receives the completed enrollment request.

- **CMS Termination of PDP Sponsor Contract -** An SEP exists for members of a PDP that will be affected by PDP sponsor contract terminations by CMS (see 42 CFR §423.509 for contract requirements on terminations). For this type of termination, PDP sponsors are required to give notice to affected members at least 30 calendar days prior to the effective date of the termination (see 42 CFR §423.509(b)(1)(ii)). To coordinate with the notification time frames, the SEP begins 1 month before the termination effective date and ends 2 months after the effective date of the termination.

  Please note that if an individual does not enroll in a new PDP before the termination effective date, he/she will be disenrolled on the effective date of the termination. However, the SEP will still be in effect for two months after the effective date of the termination should the individual wish to subsequently enroll in another PDP (for a prospective, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may choose an effective date of up to three months after the month of termination. However, the effective date may not be earlier than the date the new PDP sponsor receives a completed enrollment request.

  EXAMPLE

  If CMS terminates a PDP sponsor contract effective June 30, an SEP lasts from June 1 through August 31. In this scenario, a beneficiary could choose an effective date of July 1, August 1, or September 1; however, the effective date may not be earlier than the date the new PDP sponsor receives the completed enrollment request.

- **Immediate Terminations By CMS -** CMS will establish the SEP during the termination process for immediate terminations by CMS (see 42 CFR §423.509(b) (2) for immediate termination requirements), where CMS provides notice of termination to the PDP enrollees and the termination may be mid-month.

20.3.5 - SEP for Involuntary Loss of Creditable Prescription Drug Coverage

This SEP applies to individuals who involuntarily lose creditable prescription drug coverage, including a reduction in the level of coverage so that it is no longer creditable, not including any such loss or reduction due to the individual's failure to pay premiums. The SEP permits enrollment in a PDP and begins with the month in which the individual is advised of the loss of creditable coverage and ends 2 months after either the loss (or reduction) occurs or the individual received the notice, whichever is later. The effective date of this SEP may be the first of the month after the request or, at the beneficiary's request, may be prospective; however, it may be no more than 2 months from the end of the SEP.

20.3.6 - SEP for Individuals Not Adequately Informed about Creditable Prescription Drug Coverage

This SEP applies to individuals who were not adequately informed of the creditable status of drug coverage provided by an entity required to give such notice, or a loss of creditable coverage. This SEP permits one enrollment in, or disenrollment from, a PDP on a case-by-case-basis. This SEP begins the month the individual receives CMS approval of the SEP and continues for two additional months following this approval.

20.3.7 - SEP for Enrollment/Non-enrollment in Part D due to an Error by a Federal Employee

An individual whose enrollment or non-enrollment in Part D is erroneous due to an action, inaction or error by a Federal Employee is provided an SEP. This SEP permits enrollment in or disenrollment from a PDP on a case-by-*case basis*. This SEP begins the month the individual receives CMS approval of the SEP and continues for two additional months following this approval.

20.3.8 - SEPs for Exceptional Conditions

CMS has the legal authority to establish SEPs when an individual *or group of individuals* meets exceptional conditions specified by CMS*, including on a case-by-case basis*. *T*he SEPs *CMS has established include:*

1. SEP EGHP (Employer*/Union* Group Health Plan)- An SEP exists for individuals enrolling in employer/union *group*-sponsored Part D plans, for individuals to disenroll from a Part D plan to take employer/union-sponsored coverage of any kind, and for individuals disenrolling from employer/union-sponsored coverage (including COBRA coverage) to enroll in a Part D plan. The SEP EGHP may be used when the EGHP allow*s* the individual to make changes to their *plan* choice*s, such as during the employer's or union's "open season," or at other times the employer or union allows*.

This SEP is available to individuals who have (or are enrolling in) an employer or union plan and ends 2 months after the month the employer or union coverage ends.

The individual may choose the effective date of enrollment or disenrollment, up to 3 months after the month in which the *individuals completes an enrollment or disenrollment* request. However, the effective date may not be earlier than the *first of the month following the month in which the request was made*.

Keep in mind that all PDP eligible individuals, including those in EGHPs, may enroll in a PDP during the IEP for Part D, AEP and during any other SEP. The SEP EGHP does not eliminate the right of these individuals to enroll or disenroll during these time frames. Additionally, §50.5 outlines special processes that are available for enrollment into or disenrollment from EGHP sponsors Part D plan.

2. SEP for Individuals Who Disenroll in Connection with a CMS Sanction - On a case-by-case basis, CMS will establish an SEP if CMS sanctions a PDP sponsor, and an enrollee disenrolls in connection with the matter that gave rise to that sanction. The start/length of the SEP, as well as the effective date, is dependent upon the situation.

3. SEP for Individuals Enrolled in Cost Plans that are Non-renewing their Contracts An SEP will be available to enrollees of HMOs or CMPs that are not renewing their §1876 cost contracts for the area in which the enrollee lives if the individual is also enrolled in a Part D benefit through that Cost Plan.

This SEP is available only to Medicare beneficiaries who are enrolled in the Part D benefit through an HMO or CMP under a §1876 cost contract that will no longer be offered in the area in which the beneficiary resides. Beneficiaries electing to enroll in a PDP via this SEP must meet PDP eligibility requirements.

This SEP begins 90 calendar days prior to the end of the contract year (i.e., October 1) and ends on December 31 of the same year.

During this SEP, a beneficiary may choose an effective date of November 1, December 1, or January 1; however, the effective date may not be earlier than the date the new PDP sponsor receives the completed enrollment.

4. SEP for Individuals in the Program of All-inclusive Care for the Elderly (PACE) - Individuals may disenroll from a PDP at any time in order to enroll in PACE, including the PACE Part D benefit. In addition, individuals who disenroll from PACE have an SEP for up to 2 months after the effective date of PACE disenrollment to enroll in a PDP. The effective date would be dependent upon the situation.

5. SEP for Institutionalized Individuals – An SEP will be provided to an individual who moves into, resides in, or moves out of a:

- Skilled nursing facility (SNF) as defined in §1819 of the Act (Medicare);

- Nursing facility (NF) as defined in §1919 of the Act (Medicaid);
- Intermediate care facility for the mentally retarded (ICF/MR) as defined in §1905(d) of the Act;
- Psychiatric hospital or unit as defined in §1861(f) of the Act;
- Rehabilitation hospital or unit as defined in §1886(d)(1)(B) of the Act;
- Long-term care hospital as defined in §1886(d)(1)(B) of the Act; or
- Hospital that has an agreement under §1883 of the Act (a swing-bed hospital).

In addition, for individuals who move out of one of the facilities listed above, the individual will have an SEP for up to 2 months after he/she moves out of the facility. This SEP permits an individual to enroll in, or disenroll from, a Part D plan. The effective date is the first of the month following the month in which the enrollment/disenrollment request is received, but not prior to the month residency begins.

Please note the definition of "institution" here differs from that used in determining when an institutionalized full-benefit dual eligible qualifies for the low-income subsidy copayment level of zero.

***6*. SEP for Individuals Who Enroll in Part B during the Part B General Enrollment Period (GEP) –** An SEP will be provided to individuals who are not entitled to premium free Part A and who enroll in Part B during the General Enrollment Period for Part B (January – March) for an effective date of July 1st. The SEP will begin April 1st and end June 30th, with an effective date of July 1st.

***7*. SEP for *Non-Dual Eligible Individuals with LIS and Individuals who Lose LIS* -** *Individuals who qualify for LIS (but who do not receive Medicaid benefits) have an SEP that begins the month the individual becomes eligible for LIS and exists as long as s/he is eligible for LIS. This SEP allows an individual to enroll in, or disenroll from, a Part D plan at any time. Because this coverage is effective the first of the month, the SEP would permit beneficiaries to change enrollment on a monthly basis, if they so choose.*

All Individuals who lose their low-income subsidy eligibility:

Individuals who lose their LIS eligibility because they are no longer deemed eligible for the following calendar year will have an SEP to make a change during January – March. Those individuals who lose eligibility for LIS during the year outside of this annual process will have an SEP that begins the month they are notified and continues for two months.

The effective date for all enrollments under this SEP will be prospective, effective the first day of the month following receipt of the enrollment request by the plan.

Example: *An individual is awarded LIS and CMS facilitates his enrollment into a PDP, effective October 1st; in November, the individual decides he would rather be enrolled in another PDP and submits a request in November. He does so using this SEP and his enrollment is effective December 1st.*

***8*. MA coordinating SEPs** – The following Part D SEPs are established to coordinate with election periods in the MA program. More information about MA election periods can be found in *MA Enrollment and Disenrollment Guidance (MMCM Chapter 2)*.

A. SEP for MA-PD enrollee using the MA SEP65 - MA eligible individuals who elect an MA plan during the initial coverage election period (ICEP) surrounding their 65th birthday have an SEP called the "SEP65." The SEP65 allows the individual to disenroll from the MA plan and elect the Original Medicare plan any time during the 12-month period that begins on the effective date of coverage in the MA plan. If the individual using the SEP65 is disenrolling from an MA-PD plan, he or she may (but is not required to) use this Part D SEP to enroll in a PDP plan. This SEP must be used at the same time the SEP65 is used.

B. SEP for Individuals Who Dropped a Medigap Policy When They Enrolled For the First Time in an MA Plan, and Who Are Still in a "Trial Period" – Individuals who dropped a Medigap policy when they enrolled for the first time in an MA plan are provided a guaranteed right to purchase another Medigap policy if they disenroll from the MA plan while they are still in a "trial period." In most cases, a trial period lasts for 12 months after a person enrolls in an MA plan for the first time. If the individual is using this SEP to disenroll from is an MA-PD plan, there is a Part D SEP to permit a one time enrollment into a PDP. This SEP opportunity may only be used in relation to the MA SEP described here and *begins the month they disenroll from the MA-PD plan and continues for two additional months.*

C. SEP for an MA-PD enrollee using the MA Open Enrollment Period for Institutionalized Individuals (OEPI) to disenroll from an MA-PD plan - *I*ndividuals that meet the definition of "institutionalized" as it is provided in, and applies to, section 30.3.4 of *MA Enrollment and Disenrollment Guidance (MMCM,* Chapter 2*)* are eligible for the OEPI election period. An individual disenrolling from an MA-PD plan has an SEP to enroll in a PDP. This SEP begins with the month the individual requests disenrollment from the MA-PD plan and ends on the last day of the second month following the month MA-PD membership ended.

D. SEP for MA-PD enrollees using the MA OEP to disenroll to Original Medicare and a PDP - *I*ndividuals enrolled in MA-PD plans using the MA Open Enrollment Period (OEP) to disenroll from the MA-PD plan to Original Medicare for Part A and B benefits may only do so by enrolling in a PDP. This SEP

permitting enrollment into a PDP is in effect for MA-PD enrollees during the OEP each year and is limited to 1 enrollment**.**

E. SEP for MA-PD enrollees using the MA OEPNEW to disenroll to Original Medicare and a PDP - *I*ndividuals enrolled in MA-PD plans using the MA Open Enrollment Period for New Eligibles (OEPNEW) to disenroll from the MA-PD plan to Original Medicare for Part A and B benefits may only do so by enrolling in a PDP. This SEP permits enrollment into a PDP for MA-PD enrollees during their OEPNEW and is limited to 1 enrollment**.**

F. SEP for enrollment into MA SNPs or enrollment into a PDP after loss of special needs status - CMS is establishing an SEP to allow for disenrollment from a PDP at any time in order to enroll in an MA SNP. In addition, CMS will provide an SEP to enroll in a PDP for those who are no longer eligible for a SNP because they no longer meet special needs status (as outlined in *MA Enrollment and Disenrollment Guidance – MMCM,* Chapter 2). This SEP *begins the month the individual's special needs status changes and ends the earlier of* when the beneficiary makes an election or three months after *the effective date of the involuntary disenrollment*. The effective date would be dependent upon the situation.

***G. SEP for Enrollment into a Chronic Care SNP** - CMS will provide an SEP (for MA and Part D) for those individuals with severe or disabling chronic conditions to enroll in a SNP designed to serve individuals with those conditions. This SEP will apply as long as the individual has the qualifying condition and will end once s/he enrolls in a SNP. Once the SEP ends, that individual may make enrollment changes only during applicable MA election periods.*

***9*. SEP for Individuals who belong to a Qualified SPAP --** Individuals belong to a qualified SPAP are eligible for an SEP to make one enrollment choice at any time through the end of each calendar year (i.e. once per year). SPAP members may use this SEP to enroll in a Part D plan outside of existing enrollment opportunities, allowing them, for example, to join a Part D plan upon becoming a member of an SPAP; or to switch to another Part D plan.

1*0*. Full-Benefit Dual Eligibles With Retroactive Uncovered Months – In limited instances, a full-benefit dual eligible voluntarily enrolls in a Part D plan in the month(s) before the individual would otherwise have been auto-enrolled. The PDP may make the voluntary enrollment retroactive per Section 30.1.4.B. CMS is establishing a Special Enrollment Period (SEP) that will permit such individuals to have their voluntary enrollment be retroactive to the first day of the previous un-covered month(s) and first day of the first month of dual status.

***11*. SEP for Disenrollment from Part D to Enroll in or Maintain Other Creditable Coverage -** Individuals may disenroll from a Part D plan (including PDPs and MA-PDs)

to enroll in or maintain other creditable drug coverage (such as TriCare o*f* VA coverage). The effective date of disenrollment is the first day of the month following the month a disenrollment request is received by the Part D plan.

12. SEP for Individuals disenrolling from a Cost plan who also had the Cost plan optional supplemental Part D benefit – *Individuals who disenroll from a cost plan and the cost plan's optional supplemental Part D benefit have an SEP to enroll in a Part D plan. This SEP begins with the month the individual requests disenrollment from the cost plan and ends when the individual makes an enrollment election or on the last day of the second month following the month cost plan membership ended, whichever is earlier.*

20.4 - Effective Date of Enrollment

With the exception of some SEPs and when enrollment periods overlap, generally beneficiaries may not request their effective date of enrollment in a PDP. Furthermore, unless provided for under an SEP (e.g. EGHP or full dual retroactive as discussed in the previous section*)*, the effective date can never be prior to the receipt of an enrollment request by the PDP sponsor. An enrollment cannot be effective prior to the date the beneficiary (or their legal representative, if applicable) completed the enrollment request. This section includes procedures for handling situations when a beneficiary chooses an enrollment effective date that is not allowable based on the requirements outlined in this section.

To determine the proper effective date, the PDP sponsor must determine which enrollment period applies to each individual before the enrollment may be transmitted to CMS. This period may be determined by reviewing information such as the individual's date of birth, Medicare card, and by the date the PDP sponsor receives the enrollment request.

Once the PDP sponsor identifies the enrollment period, the PDP sponsor must determine the effective date. In addition, PDP enrollments for EGHP sponsored PDP plans and full benefit dual eligible enrollments may be retroactive under certain circumstances (refer to §50.5 for more information on EGHP retroactive effective dates).

Examples for determining the effective date:

A. On August 18, 2007, Mrs. Jones submits an enrollment request to a PDP sponsor. Her enrollment form shows she became entitled to Medicare Parts A and B in March 2002. She has indicated on her enrollment form that she lives in a long-term care facility. What is her effective date?

   Explanation: Since the date the request was received is August 18, 2007, this is not an AEP request. The entitlement date for Medicare Parts A and B shows that she is not in her IEP for Part D. That leaves only an SEP. Mrs. Jones indicated that she resides in a long-term care facility, so this enrollment request can be

processed under the SEP for Institutionalized Individuals (see §20.3.8, item # 5). The effective date for this enrollment is September 1, 2007.

B. Mr. Doe calls a PDP sponsor for information about Part D on October 3, 2006. The PDP representative discusses the PDP plans available and the enrollment requirements, including when an individual may enroll. Mr. Doe tells the representative that he is retiring and his employer coverage will end on October 31, 2006. He submits an enrollment request on October 24, 2006. His entitlement to Medicare Parts A and B is June 1, 1994. He indicates on the request that he does not reside in a long-term care facility.

   Explanation: Since the date the request was received is October 24, 2006, this is not an AEP request. The entitlement date for Medicare Parts A and B shows he is not in his IEP for Part D. No other details on the request itself point to any specific enrollment period, however we know that he has retired and his employer sponsored commercial coverage is ending. The enrollment can be processed using the SEP EGHP (see §20.3.8, item # 1). Mr. Doe can choose an effective date of up to 3 months after the month in which the request is made. The PDP sponsor contacts Mr. Doe, confirms his retirement, explains the SEP EGHP and asks him about the effective date. Since his employer coverage is ending on October 31, 2006, he requests a November 1, 2006, effective date.

Effective dates for Enrollment Periods:

Part D Enrollment Period	**Effective Date**
<u>Annual Coordinated Election Period (AEP):</u> The AEP begins on November 15 and continues through December 31 of every year. Individuals have one AEP enrollment to use – once this enrollment is effective, the AEP has been used.	January 1st of following year.

Initial Enrollment Period for Part D (IEP for Part D): For individuals that become Part D eligible after January 2006, generally the IEP for Part D is concurrent with the initial enrollment period for Part B. (Note: The Initial Enrollment Period for Part B begins 3 months prior to the month of Medicare eligibility, and ends on the last day of the third month following the month of Medicare eligibility.) *Example: Mrs. Jones is eligible for Medicare on July 1, 2006. Her Part B Initial Enrollment Period is April 1, 2006 through October 31, 2006. Therefore her IEP for Part D is also July 1, 2006 through October 31, 2006.* If individuals had not been eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B or those not eligible for Part D during first Medicare initial enrollment period for Part D that occurred from November 15, 2005 through May 15, 2006, their IEP for Part D is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility to Part D. *Individuals eligible for Medicare prior to age 65 (such as for disability) will have another IEP for Part D based upon attaining age 65.*	Enrollment requests made prior to the month of eligibility are effective the first day of the month of eligibility. Enrollment requests made during or after the first month of eligibility are effective the 1st of the month following the month the request was made.
Special Enrollment Periods (SEP): SEPs for PDP enrollment and disenrollment choices are described in section 20.3 of this guidance.	Effective dates are dependent upon the individual SEP and circumstances.

It is possible for an individual to make an enrollment request when more than one enrollment and disenrollment period applies, and therefore it is possible that more than one effective date could apply. If an individual requests enrollment when more than one enrollment period applies, a PDP sponsor must allow the individual to choose the enrollment period (and therefore the effective date) in which he/she is enrolling (see exception in the next paragraph regarding the IEP for Part D).

If the individual's IEP for Part D and another enrollment period overlap, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

EXAMPLE

- If an individual's IEP for Part D starts in November, (i.e., he will be entitled to Medicare Part A and Part B in February) and a PDP sponsor receives an enrollment request from that individual during the AEP, then the individual may

NOT choose a January 1 effective date (for the AEP) and must instead be given a February 1 effective date (for the IEP for Part D) because January 1st is earlier than the month of entitlement to Medicare Part A and/or enrollment in Part B.

If an individual makes an enrollment request when more than one enrollment period applies but does not indicate or choose an effective date as above, then the PDP sponsor must attempt to contact the individual to determine the individual's preference. If unsuccessful, the PDP sponsor must use the following ranking of enrollment periods (1 = Highest, 3 = Lowest). The enrollment period with the highest rank determines the effective date in this situation.

Ranking of Enrollment Periods: (1 = Highest, 3 = Lowest)

1. IEP for Part D

2. SEP

3. AEP

20.5 - Effective Date of Voluntary Disenrollment

PDP enrollees may voluntarily disenroll from a PDP during the AEP and SEP as described in §§20.2 and 20.3 of this guidance. With the exception of some SEPs and when enrollment periods overlap, generally beneficiaries may not choose the effective date of disenrollment. This section includes procedures for handling situations when a beneficiary chooses a disenrollment effective date that is not allowable based on the requirements outlined in this section.

A PDP enrollee may disenroll through the PDP sponsor or 1-800-MEDICARE. If an enrollee enrolls in a new PDP, during an available enrollment period, while still enrolled in another PDP, he/she will automatically be disenrolled from the old PDP and enrolled in the new PDP by CMS systems with no duplication or delay in coverage. Further, individuals enrolled in any MA plan (except for an MA Private Fee-For-Service (PFFS) plan that does not offer a Part D benefit or a Medicare Medical Savings Account (MSA) plan) will be disenrolled from that MA plan upon successful enrollment in a PDP.

As with enrollments, it is possible for an individual to make a disenrollment request when more than one enrollment period applies. Therefore, in order to determine the proper effective date, the PDP sponsor must determine which period applies to the request to determine the effective date of disenrollment before the disenrollment transaction may be transmitted to CMS.

If a PDP sponsor receives a completed disenrollment request when more than one period applies, the PDP sponsor must allow the member to choose the effective date of disenrollment (from the possible dates, as provided by the enrollment/disenrollment

periods that overlap). If the member does not make a choice of effective date, then the PDP sponsor must give the effective date that results in the **earliest** disenrollment. The procedure for determining the enrollment/disenrollment period is the same as described in §20.4 of this guidance.

Effective dates for voluntary disenrollment are as follows. (Refer to §§40.2 and 40.3 for effective dates for involuntary disenrollment.)

Enrollment Period	**Effective Date of Disenrollment***	**Do PDP sponsors have to accept disenrollment requests in this enrollment period?**
Annual Coordinated Election Period	January 1 of the following year.	Yes
Special Enrollment Period	Varies, as outlined in §20.3	Yes

***NOTE:** CMS Regional Offices may allow up to 90 days retroactive payment adjustments for EGHP sponsored PDP disenrollments. Refer to §50.5 for more information.

As stated previously, individuals generally cannot choose the effective date of disenrollment. The enrollment/disenrollment period during which the request is received dictates the effective date. If an individual requests a disenrollment date that is not permissible, the PDP sponsor should advise the individual and process the request according the requirements in this guidance.

30 - Enrollment Procedures

A PDP sponsor must accept all enrollment requests it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, through CMS auto-enrollment or facilitated enrollment processes, or through other mechanisms defined by CMS (and offered by the PDP sponsor).

Upon receiving an enrollment request, a PDP sponsor must provide within 10 calendar days, one of the following:

- *Notice of acknowledgement (as described in section 30.4.1);*
- *Request for additional information (as described in 30.2.2); or*
- *Notice of denial (as described in 30.2.3).*

The individual (or his/her legal representative) must complete an enrollment request and include all the information required to process the enrollment, or an enrollment may be generated by other processes specified by CMS. PDP sponsors may accept faxed enrollment requests and need not obtain the original.

CMS will provide weekly Transaction Reply Reports, or TRRs as well as a monthly TRR. *Unless otherwise directed in this guidance, t*he PDP sponsor *must* provide notice in response to *information* received from CMS on either the weekly or monthly TRR*, whichever contains the earliest notification.*

Annual Coordinated Election Period (AEP):

PDP sponsors *may not solicit submission of paper enrollment forms or accept telephone or on-line enrollment requests prior to the beginning of the AEP on November 15th* . However, CMS recognizes that organizations may receive paper enrollment requests prior to the start of the AEP on November 15th since marketing activities may begin on October 1*st*. *I*f paper enrollment forms are received on or after October 1*st* and prior to November 15*th*, PDP organizations must retain and process them as follows:

- Within 7 calendar days of the receipt of a paper enrollment request, the plan must provide the beneficiary with a written notice that acknowledges receipt of the enrollment request *(Exhibit 2)*, and indicates that the enrollment will take effect on January 1*st* effective date *of the following year*.

- For *AEP* enrollment requests received prior to November 15*th* plans must submit all transactions to CMS systems (MARx) on November 15*th* with an "application date" of November 15th *of the current year. For example, unsolicited AEP paper enrollment requests received October 1 through November 14, 2007, must be submitted on November 15, 2007, with an application date of November 15, 2007. If a beneficiary has submitted more than one AEP paper enrollment request prior to November 15th, the beneficiary will be enrolled in a plan based on the first application that is processed.*

- Once the PDP sponsor receives a MARx *transaction* reply report from CMS indicating whether the individual's enrollment has been accepted or rejected, the PDP sponsor must meet the remainder of the requirements (e.g., sending a notice of the acceptance or rejection of the enrollment within *10 calendar* days following receipt of the reply report from CMS) provided in Section 30.4.

Note: If organizations receive incomplete unsolicited AEP paper enrollment requests prior to November 15th, they must follow existing guidance for working with beneficiaries to complete the applications.

Again, this policy applies only to unsolicited paper enrollment forms requesting an AEP enrollment for January 1*st*. To help ensure a successful AEP season, it is imperative that plans follow these steps and submit valid enrollment transactions promptly as directed.

30.1 - Format of Enrollment Requests

All PDP sponsors must have, at minimum, a paper enrollment form available for potential enrollees to request enrollment in a PDP. PDP sponsors may also accept enrollment elections made via the on-line enrollment center hosted by CMS, as well as requests for enrollment as described in §§30.1.1 – 30.1.6.

No PDP enrollment request vehicle, regardless of format, may include any question regarding health screening information.

The PDP sponsor's enrollment vehicle(s) must include information that the individual acknowledges, as follows:

- Agrees to abide by the PDP sponsor's membership rules as outlined in material provided to the member;
- Consents to the disclosure and exchange of information necessary for the operation of the Part D program;
- Understands that enrollment in the PDP automatically disenrolls him/her from any other PDP, MA plan (as described in §20.6 of this guidance) or PACE plan in which he/she is enrolled;
- Understands that if enrollment requests are submitted for more than one plan with the same effective date, the last choice made will generally be the one that takes effect;
- *Is advised of* the expected effective date of enrollment in the PDP; and
- Knows he/she has the right to appeal service and payment denials made by the organization.

Refer to §50.*8* for requirements regarding retention of enrollment requests.

30.1.1 - Paper Enrollment Forms

All PDP sponsors must, as a minimum standard, have a paper enrollment form that complies with CMS' guidelines in format and content and a process as described in this guidance for accepting it. A model enrollment form is included in **Exhibit 1**.

30.1.2 - Enrollment via the Internet

PDP sponsors may develop and offer enrollment requests into a PDP via a secure internet web site. The following guidelines must be applied, in addition to all other program requirements.

- Submit all materials and web pages related to the on-line enrollment process for CMS approval following the established guidelines for the review and approval of marketing materials and enrollment request vehicles.
- Provide beneficiaries with all the information required by CMS' marketing guidelines for the Part D program.
- The PDP sponsor must, at a minimum, comply with the CMS internet architecture requirements found at: http://cms.hhs.gov/it/security/ The PDP sponsor may also include additional security provisions.
- Advise each individual at the beginning of the online enrollment process that he/she is sending an actual enrollment request to the PDP sponsor.
- Capture the same data required on the *model* enrollment form (see **Exhibit 1 and Appendix 2**).
- As part of the online enrollment process include a separate screen or page that includes an "enroll now," or "I agree," type of button, that the individual must click on to indicate his/her intent to enroll and agreement to the release and authorization language (as provided on the model enrollment form, see Exhibit 1) and attest to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information.
- Inform the individual of the consequences of completing the internet enrollment, i.e. that s/he will be enrolled (if approved by CMS), and that s/he will receive a notice (an acceptance or denial notice) following submission of the enrollment to CMS.
- Include a tracking mechanism to provide the individual with evidence that the internet enrollment request was received, for example, a confirmation number.
- *M*ay not request or collect premium payment or other payment information, such as bank account information or credit card numbers.
- Maintain electronic records that are securely stored and readily reproducible for the period required in this guidance.

Medicare Online Enrollment Center:

In addition to the process described above, CMS offers an on-line enrollment center through the www.medicare.gov web site and the 1-800-MEDICARE call center for enrollment into Medicare prescription drug plans. The date and time "stamped" by the Medicare Online Enrollment Center will serve as the enrollment *request* date *(i.e. application date)* for purposes of determining the election period and enrollment effective date.

30.1.3 - Enrollment via Telephone

PDP sponsors may accept enrollment requests into one or more of its PDPs via an incoming (in-bound) telephone call. The following guidelines must be followed, in addition to all other program requirements:

- Enrollment requests may only be accepted from/during an incoming (or in-bound) telephone call from a beneficiary.
- Individuals must be advised that they are completing an enrollment.
- Each telephonic enrollment request must be recorded and include statements of the individual's agreement to be recorded, required elements necessary to complete the enrollment (as described in Appendix 2), and a verbal attestation of the intent to enroll. All telephonic enrollment recordings must be maintained as provided in §50.*8* of this guidance.
- Collection of financial information is prohibited at any time during the call.
- A notice of acknowledgement and other required information must be provided to the individual as described in §30.4 of this guidance.

The PDP sponsor must ensure that all Part D eligibility and enrollment requirements provided in this guidance are met.

Scripts for completing an enrollment request in this manner must be developed by the PDP sponsor, must contain the required elements for completing an enrollment request as described in Appendix 2 of this guidance, and must obtain CMS approval following existing marketing material approval procedures prior to use.

30.1.4 - Auto- and Facilitated Enrollment

CMS auto and facilitates enrollment of certain LIS beneficiaries into PDPs. "Auto-Enrollment" is the process that refers to full-benefit dual eligibles. "Facilitated Enrollment" is the process that refers to other LIS beneficiaries. Both processes occur monthly. The primary differences between the two are the populations and the effective date.

A. Populations

1. Auto-Enrollment.

Full-benefit dual eligible individuals who have not elected a Part D plan will be auto-enrolled into one by CMS. Full-benefit dual eligible individuals are defined as those eligible for comprehensive Title XIX Medicaid benefits as well as eligible for Medicare Part D. This includes those who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare cost-sharing (sometimes known as QMB-plus or SLMB-plus). CMS will use data provided by State Medicaid Agencies to identify full-benefit dual eligible individuals. Please note that full-benefit dual eligible individuals do not include those eligible only for Medicaid payment of Medicare cost-sharing (i.e. QMB-only, SLMB-only, or QI).

Full-benefit dual eligible individuals who will be auto-enrolled into a PDP pursuant to this section include those enrolled in:

- *Original Medicare*
- *A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit*
- *An 1876 cost plan that does not offer a Part D optional supplemental benefit*
- *Medical Savings Account*
- *An 1833 Health Care Prepayment Plan (HC-PP)*

This excludes full-benefit dual eligible individuals who:

- *Live in any of the five U.S. territories*
- *Live in another country*
- *Are inmates in a correctional facility*
- *Have opted out of auto-enrollment into a Part D plan*
- *Are already enrolled in a Part D plan*
    - *Note: beneficiaries enrolled in Programs for the All-inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their PACE organization, so they do not need to be auto-enrolled*
- *Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan, other than an MA-PFFS plan that does not offer Part D or an MSA plan. CMS will instead direct Medicare Advantage organizations to facilitate the enrollment of these individuals into an MA-PD plan offered by the same MA organization; please see Section 40.1.6 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2).*
- *Are enrolled in an 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be auto-enrolled instead into the cost plan's Part D optional supplemental benefit, as will be described under Chapter 17, Subpart D of the Medicare Managed Care Manual).*

2. Facilitated Enrollment.

Other LIS eligibles are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e. only eligible for Medicaid payment of Medicare cost-sharing); SSI-only (Medicare and SSI, but no Medicaid); or those who apply for LIS at the Social Security Administration (SSA) or a State Medicaid Agency and are determined eligible for LIS. This includes those who apply and are determined eligible for either the full or partial subsidy. CMS will use data submitted by SSA to identify SSI-only and those who apply for LIS and are determined eligible by SSA. CMS will use data from State Medicaid Agencies to identify those who are QMB-only, SLMB-only, QI, or who apply for LIS and are determined eligible by the State.

Other LIS eligibles who will be enrolled into PDPs pursuant to this section include those enrolled in:

- *Original Medicare*
- *A Medicare Advantage Private Fee-for-Service (MA-PFFS) plan that does not offer a Part D benefit*
- *An 1876 cost plan that does not offer a Part D optional supplemental benefit*

- *A Medical Savings Account (MSA)*
- *An 1833 HCPP*
- *Who do not meet any of the conditions listed below.*

This excludes other LIS eligibles who:

- *Live in any of the five U.S. territories*
- *Live in another country*
- *Are individuals for whom the employer is claiming the retiree drug subsidy*
- *Are inmates in a correctional facility*
- *Have affirmatively declined Part D benefits*
- *Are already enrolled in a Part D plan*
    - *Note: beneficiaries enrolled in Programs for the All-inclusive Care for the Elderly (PACE) receive all their Medicare benefits, including Part D benefits, through their PACE organization, so they do not need to be auto-enrolled*
- *Are not eligible to enroll in a PDP because they are enrolled in a Medicare Advantage plan (these individual will be facilitated enrolled instead into an MA-PD plan; please see Section 40.1.6 of MA Enrollment and Disenrollment Guidance (MMCM, Chapter 2)*
    - *Note: the only exception are those enrolled in an MA-PFFS plan that does not offer Part D*
- *Are enrolled in an 1876 cost plan that offers a Part D optional supplemental benefit (these individuals will be facilitated enrolled instead into the cost plan's Part D optional supplemental benefit).*

B. Auto/Facilitated Enrollment Process

The procedure for auto- and facilitated enrollment into PDPs are identical, and work as follows:

1. *CMS will identify full-benefit dual eligible individuals to be auto-enrolled and other LIS eligibles to be facilitated enrolled. CMS uses LIS deemed reason code, which indicates the person was a full benefit dual eligible sometime during the past year, to define those being auto-enrolled. LIS deemed code and LIS applicant data are used to identify those who need to be facilitated enrolled..*

2. *CMS will assign beneficiaries to a plan in a two-step process. The first level of assignment is at the PDP sponsoring organization (PDP Sponsor) level. The second level of assignment is to an individual PDP offered by the PDP Sponsor. This will result in approximately the same proportion of auto-enrollees at the PDP Sponsor level.*

   At the first level of assignment, CMS will identify PDP Sponsors that offer at least one PDP in the region offering basic prescription drug coverage with a premium

at or below the low-income premium subsidy amount in each PDP region. If more than one PDP Sponsor in a region meets the criteria, CMS will auto/facilitate enroll on a random basis among available PDP Sponsors. Please note that if two or more PDP sponsors are owned by the same parent organization, they are treated as a single organization for purposes of this first step of auto/facilitated enrollment.

At the second level of assignment, CMS will identify the PDPs in the region offering basic prescription drug coverage with premiums at or below the low-income premium subsidy amount that are offered by each qualifying PDP Sponsor. If a given PDP Sponsor only has one such PDP in the region, all the beneficiaries assigned to the PDP Sponsor will be assigned to that one PDP. If the PDP Sponsor offers more than one PDP in the region offering basic prescription drug coverage with a premium at or below the low-income premium subsidy amount, beneficiaries will be randomly assigned among available PDPs.

This method of random enrollment will result in full-benefit dual eligibles and other LIS beneficiaries being assigned in approximately equal proportions among available PDP Sponsors, not PDPs. Since PDP Sponsors may offer different numbers of PDPs that meet the auto/facilitated enrollment criteria, auto/facilitated enrollment proportions may vary at the PDP level.

EXAMPLE:

> *There are 4 PDP Sponsoring organizations in a region that offer one or more plans with premiums at or below the low income premium subsidy amount. The numbers of PDPs with an appropriate premium are as follows:*
>
> *Organization A—1 PDP*
> *Organization B—1 PDP*
> *Organization C—2 PDPs*
> *Organization D—3 PDPs*
>
> *Step 1: The auto/facilitated enrollment population would first be divided equally and randomly among the four PDP sponsors. Thus, each PDP Sponsor would be assigned 25 percent of the available population.*
>
> *Step 2: Within each PDP Sponsor, the population would again be divided equally and randomly. Thus, all of Organization A's enrollees would be assigned to its one appropriate PDP; the same would be true for Organization B; 50 percent of the population assigned to Organization C would be assigned randomly to each of its two plans; and 33.3 percent of the population assigned to Organization D would be assigned randomly to each of its three plans.*

PDPs with premiums below the low-income subsidy amount will not be treated more favorably than those with premiums equal to the low-income premium subsidy amount. A PDP's other beneficiary charges – copayment levels, deductibles, etc. – will not be a factor in determining whether it qualifies for auto/facilitated enrollment provided the PDP offers basic prescription drug coverage.

Only PDPs with defined standard, actuarially equivalent standard, or basic alternative benefit packages will be included. CMS will not auto/facilitate enroll beneficiaries into PDPs with enhanced alternative benefit packages, even if their premium is at or below the low-income premium subsidy amount for the region. In addition, CMS will not auto/facilitate enroll into an employer-sponsored PDP.

CMS will create an enrollment transaction for each auto and facilitated enrollment into the PDP. Immediately after auto/facilitated enrollment occurs, the PDP will receive the preliminary "PDP notification file" identifying those assigned, as well as their addresses and full names. This ensures PDPs are notified prior to beneficiaries receiving CMS' auto/facilitated enrollment notice. The PDP will then be notified via the weekly transaction reply report of the auto/facilitated enrollment confirmed processed by MARx, including the effective date. Finally, the PDP will also receive a supplemental report with address information of those confirmed auto/facilitated enrolled, since these data are not on the transaction reply. Since CMS does not maintain phone number data on beneficiaries, this information is not available to PDP sponsors. For technical specifications and file formats, please see sections 8.2 and E.2 of the Plan Communications User Guide, on the CMS website at http://www.cms.hhs.gov/medicaremangcaresys/01_overview.asp?.

For auto-enrollments with a retroactive effective date in the previous calendar year, CMS will assign to PDPs that (1) have a PDP in the current year is below de minimis and has a basic benefit package, and (2) that same PDP qualified for auto/facilitated enrollment in the previous calendar year.

C. Effective Date

1. Auto-Enrollment for Full-Benefit Dual Eligible Individuals:

For full-benefit dual eligible individuals who are Medicaid eligible first and then subsequently become Medicare eligible, the effective date of auto-enrollment will be the first day of Part D eligibility. This effective date ensures there is no coverage gap between the end of Medicaid prescription drug coverage and the start of Medicare prescription drug coverage. CMS will make every effort to identify these individuals prior to the start of their Part D eligibility, so that we can notify beneficiaries and plans prospectively of auto-enrollment. However, in cases where we cannot do so, the

enrollment may be retroactive. Please note that Part D eligibility always falls on the first day of the relevant month.

Example: An individual has Medicaid coverage throughout 2007. In May 2007, the individual becomes eligible for Medicare Part D. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2007; the first day of Part D eligibility is May 1, 2007. Auto-enrollment is effective May 1, 2007.

Retroactive eligibility for Medicare Parts A and/or B will not result in retroactive effective dates for auto-enrollment. This is because Medicare Part D eligibility cannot be retroactive. If eligibility for Part A and/or B is retroactive, Part D eligibility is effective the first day of the month in which the beneficiary received notification of retroactive Medicare Part A/B entitlement (see §10).

Example: An individual has Medicaid coverage throughout 2007. In May 2007, the individual is notified that s/he is entitled to Medicare Part A and/or B retroactive to November, 2006. The last day of eligibility for Medicaid prescription drug coverage is April 30, 2007; the first day of Part D eligibility is May 1, 2007. Auto-enrollment is effective May 1, 2007.

For those who are Medicare eligible first, and then subsequently become Medicaid eligible, auto-enrollment will be effective the first day of the month the person became Medicaid eligible (i.e. achieved full-benefit dual status), or January 1, 2006, whichever is later. For this population, there is no data that can be used to identify them prospectively, so the effective date will likely always be retroactive. Please note that auto-enrollment will only occur if the beneficiary is not already enrolled in a Part D plan; if the person is already in a Part D plan, the only impact of becoming newly eligible for Medicaid is that the individual will be deemed eligible for the full low-income subsidy.

Example: An individual is currently entitled to Medicare Parts A and B. In August 2007, the person becomes Medicaid eligible. Because the person has Medicare, she/he is not eligible for Medicaid prescription drug coverage (note she/he remains eligible for other Medicaid benefits). The state includes this person on their September file to CMS. CMS uses this September data in its October auto-enrollment run, and notifies the beneficiary in late October where she/he will be auto-enrolled. Auto-enrollment is effective retroactive to August 1, 2007.

Example: An individual becomes Medicare Part D eligible in May 2007. That same month, the individual applies for Medicaid. In August 2007, the State Medicaid Agency awards Medicaid eligibility effective February 1, 2007 (Medicaid eligibility may be retroactive to three months before the month of application). In this scenario, Medicaid prescription drug coverage is effective February 1 – April 30, 2007. The State sends data to CMS in August identifying this person as newly dual eligible back to May 1. CMS uses this data submitted in August in its September auto-enrollment run. Auto-enrollment is effective May 1, 2007. CMS will

notify the person of this retroactive enrollment, and inform the person of his/her Special Enrollment Period, which permits the person to change plans prospectively at any time.

CMS will auto-enroll full-benefit dual eligibles who have disenrolled, either voluntarily or involuntarily, from a Part D plan and failed to enroll in a new plan (unless they affirmatively declined or opted-out of auto-enrollment). The effective date will be retroactive to the month after the disenrollment effective date of the previous Part D plan enrollment.

Example: A full-benefit dual eligible disenrolls from a Part D plan (either voluntarily or involuntarily), effective March 31, 2007. In the April auto-enrollment run, CMS identifies this beneficiary, and notifies him/her in late April that s/he will be auto-enrolled effective retroactive to April 1, 2007.

CMS will calculate the auto-enrollment effective date, which will be conveyed to plans in the transaction reply. CMS will ensure that any beneficiary choice will "trump" auto-enrollment by creating an artificially early application receipt date for systems processing purposes.

In limited instances, a full-benefit dual eligible voluntarily enrolls in a Part D plan in the month(s) before the individual would otherwise have been auto-enrolled, or CMS auto/facilitates enrollment of a beneficiary with a given effective date, but subsequently data become available that show the effective date should have been earlier. Individuals with active elections in a Part D plan are not included in CMS' auto-enrollment process. However, since an individual's elected enrollment normally would not be effective until the first day of the following month, this would mean that the individual would have a coverage gap before the effective date of the election and thus would likely incur out-of-pocket prescription drug costs.

To remedy this situation, PDPs must make the effective date of such an enrollment retroactive to the first day of the previous un-covered month(s) (see Section 20.3.8, #12 for SEP established for this purpose). The effective date is retroactive only to the beginning of the month in which there were out-of-pocket costs, not necessarily all months in which there was no Part D plan enrollment. Please note that the beneficiary must have been a full-benefit dual eligible during each of the uncovered month(s), and received Part D-covered prescription drugs during this time (whether paid by the beneficiary, someone on their behalf, or pending payment). Where these cases originate with CMS, caseworkers in CMS' Regional Offices will take the appropriate action and notify the PDP. If a full-benefit dual eligible member requests this retroactive coverage directly from the PDP, the PDP must develop the retroactive request and submit it to CMS Division of Payment Operations.

2. Facilitated Enrollment

The effective date for the facilitated enrollment of other LIS eligible individuals will be prospective. Specifically, the effective date of facilitated enrollment is the first day of the second month after CMS identifies the person. This is true even if CMS receives data identifying the person as retroactively eligible for LIS.

> *Example: Throughout 2007, an individual is eligible for Part D. In July, 2007, the State sends data to CMS identifying the person as QMB-only, SLMB-only, or QI, retroactive to March 1, 2007. The person is included in the August facilitated enrollment run. CMS notifies the person in August where she/he will be facilitated enrolled if she/he does not voluntarily choose by September 30. Facilitated enrollment is effective October 1, 2007.*

Facilitated enrollment will be prospective, even in cases of retroactive entitlement to Medicare Parts A and/or B. This is because if entitlement to Part A and/or B is retroactive, Part D eligibility is effective the first day of the month in which the beneficiary received notification of retroactive A/B (see Section 10).

CMS will calculate the facilitated enrollment effective date, which will be conveyed to plans in the transaction reply. CMS will ensure that any beneficiary choice will "trump" facilitated enrollment by creating an artificially early application receipt date for systems processing purposes.

The PDP must move up the effective date of a facilitated enrollment by a month if an Other LIS beneficiary requests this in a timely fashion, i.e. before the start of the earlier month. If the person is a partial dual eligible, the SEP under section 20.3.2 should be used. If the person is an SSI-only eligible or an individual who applied and was determined eligible for LIS by SSA or a State Medicaid Agency, the SEP under section 20.3.8 #8 is available.

> *Example: CMS facilitates enrollment of an Other LIS eligible in May, 2007, effective July 1, 2007. The beneficiary receives the facilitated enrollment notice in May, and by May 31 requests the PDP makes the facilitated enrollment effective June 1. The PDP submits an enrollment transaction to do so.*

***D. CMS Notice Provided to Auto/Facilitated Enrolled Beneficiaries**:*

CMS will notify the beneficiary that she/he will be auto/facilitated enrolled in a given PDP on the auto/facilitated enrollment effective date unless s/he chooses another Part D plan (either another PDP, or an MA-PD plan, a PACE organization, or an 1876 cost plan that offers a Part D optional supplemental benefit), or opts out of auto/facilitated enrollment into a Part D plan altogether. If the beneficiary does not take either action, the person's silence will be deemed consent with the auto/facilitated enrollment, and it will take effect on the effective date.

In cases where the auto-enrollment effective date is retroactive, the beneficiary will not be able to change Part D plans prior to auto-enrollment taking effect. In addition, LIS eligible individuals have a Special Enrollment Period (SEP) that permits them to change Part D plans at any time, even after the auto/facilitated enrollment takes effect (refer to section 20.3.2 of this guidance). However, plans may cancel an auto-enrollment that has a retroactive date, upon beneficiary request, through the 15th of the month after the month in which auto-enrollment occurred.

> *Example: In October, 2007, CMS auto-enrolls a full-benefit dual eligible effective retroactively to August 1, 2007. The beneficiary has until November 15 to request cancellation of the retroactive effective date. After that, the request will follow normal disenrollment request rules, and be effective the first day of the month after the individual makes the request to disenroll.*

Should CMS modify the auto-enrollment procedure for those with RDS, CMS will provide a targeted auto-enrollment notice to full-benefit dual eligibles with RDS.

E. PDP Notice and Information Provided to Auto/Facilitated Enrolled Beneficiaries:

*PDPs must send a notice confirming the auto-enrollment (see **Exhibit 24**) or facilitated notice (see **Exhibit 25**) within 10 calendar days after receiving CMS confirmation of the enrollment from the transaction reply report (TRR) or the earlier CMS file with addresses of auto-enrollees, whichever is later. If the PDP receives notification that an auto-enrollment of a full-benefit dual eligible was rejected because the person had RDS, the PDP must send a targeted notice (see Exhibit 5a) and follow the procedures in subsection G.*

PDPs must also send a modified version of the pre- and post-enrollment materials that must be provided to those who voluntarily enroll in a PDP. If the address indicates the beneficiary is outside the PDP region, please follow procedures in section 40.2.1. If the effective date is retroactive into the previous calendar year, only send the current year's version of the pre-and post-enrollment documents listed below.

Prior to the effective date, the PDP must send each individual who has been auto/facilitated enrolled:

- *Evidence of health insurance coverage so that he/she may begin using the plan services as of the effective date;*

  > ***NOTE:** This is not the same as the Evidence of Coverage document described in CMS' marketing guidelines. This evidence may be in the form of member cards, the enrollment form, and/or a notice to the member. If the PDP sponsor does not provide the member card prior to*

the effective date, it must provide it as soon as possible after the effective date.

- *The charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts (including general information about the low income subsidy);*

- *The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the PDP sponsor has not yet provided the ID card); AND*

- *A Summary of Benefits. Those who are auto/facilitated enrolled still need to make a decision whether to stay with the plan into which they have been auto-enrolled or change to another one that better meets their needs. Providing the Summary of Benefits, which is generally considered pre-enrollment marketing material, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.*

After the effective date of coverage:

- *If the PDP is not notified early enough of an auto/facilitated enrollment to meet the timelines on materials required to be provided prior to the effective date (as discussed above), the PDP sponsor must provide the individual all materials described above no later than 10 calendar days after notification of auto/facilitated enrollment (see first paragraph in this section for specifics on timeline).*

The requirement to inform the beneficiary of whether the enrollment was accepted or rejected does not apply to auto/facilitated enrollments, since CMS generates these transactions.

*There may be certain times during the month death information is updated in CMS records after the auto-assignment/enrollment process has occurred, resulting in auto-enrollment of individuals with a deceased code. In cases where the PDP sponsor receives an auto-enrollment with a deceased code, the PDP sponsor must send a notice to the estate of the member (see **Exhibit 13a).***

***F. Opt Out**:*

*Full-benefit dual eligible and other LIS eligible individuals may opt out of (affirmatively decline) auto/facilitated enrollment into a Part D plan. The primary means for doing so is by calling 1-800-MEDICARE. However, the beneficiary may also call the PDP into which he/she has been auto/facilitated enrolled. The entity contacted by the beneficiary must inform the individual of the implications of his/her request. In addition, a follow-up notice must be provided that confirms the request to opt-out, and explains the consequences (**see Exhibit 26**). The entity then sends a 51 disenrollment transaction and sets the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment)*

The beneficiary may opt-out either prior to the auto/facilitated enrollment effective date, or once enrolled in a Part D plan (whether voluntarily or auto/facilitated enrolled into it). If the beneficiary makes the request prior to the effective date of auto/facilitated enrollment, then the entity receiving the opt-out request will submit a disenrollment transaction (with specific coding indicating that the transaction is an opt-out). This will cancel the auto/facilitated enrollment, and the person will never be enrolled. If the beneficiary makes the request once enrolled in the plan, then the request results in a disenrollment effective the last day of the month in which the request was made. The exception is for auto-enrollees with a retroactive effective date, who may request a retroactive cancellation, as long as the request is made by the end of the month the beneficiary was notified of auto-enrollment.

Please note that an individual who opts-out does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto/facilitated enrollment processes.

If the beneficiary decides she/he wants to obtain the Part D benefit in the future, she/he does so simply by enrolling in a new plan. LIS eligible individuals have a Special Enrollment Period, so they can enroll at anytime; they are not limited to the AEP. The enrollment request will be effective the first of the month following the month in which the Part D plan receives the enrollment request.

G. Special Procedures for Full Benefit Dual Eligibles with Retiree Drug Subsidy

CMS is considering additional modifications to the procedure for auto-enrolling full-benefit dual eligible individuals with employer coverage (including RDS) and will provide these updates in future guidance.

Section 30.1.5 Re-Assignment of Certain LIS Beneficiaries

CMS has the discretion to re-assign LIS beneficiaries, including situations in which their current plan will have a premium above the low-income premium subsidy amount in the following year. CMS will conduct the reassignment in the fall of each year, and ensure all affected LIS beneficiaries are notified. Affected PDPs are not responsible for initiating any enrollment or disenrollment transactions for reassigned beneficiaries, except for re-enrollment of beneficiaries who opt to remain in their current plan, as described below. Affected PDPs are only responsible for responding to the CMS enrollment transaction promptly when they receive it and for providing appropriate beneficiary notices and materials, also as described below.

A. Population to be Re-Assigned

CMS will reassign beneficiaries who meet all of the following criteria:

For PDPs that will have a premium in the following year that will be above the "de minimis" amount or are converting to an enhanced benefit:

- *They were deemed eligible for LIS because they were a full benefit dual eligible, Medicare Savings Program participant, or Supplemental Security Income (SSI) recipient; OR because they applied and were found eligible for LIS.*
- *They will continue to be eligible for 100% premium subsidy LIS in 2007.*
- *They were originally auto/facilitated enrolled into their current Prescription Drug Plan.*
- *They did not voluntarily elect another plan.*

For PDPs that are non-renewing (terminating)

- *All current LIS enrollees who will continue to have LIS in the following year, regardless of premium subsidy amount, and regardless of whether the individual was assigned to or voluntarily enrolled in a plan*

B. Re-assignment Process

A PDP will lose LIS beneficiaries to re-assignment if the PDP has beneficiaries originally auto/facilitated enrolled by CMS and:

- *the PDP premium was at or below the de minimis amount in the current year and renews in the following year with a premium that exceeds the following year's low-income premium subsidy amount by more than the de minimis amount;*
- *the PDP is renewing with an enhanced benefit package in the following year; or*
- *the PDP is terminating for the following year.*

CMS will first identify other plans in the same region sponsored by the same organization that offer basic prescription drug coverage and will have a premium at or below the low-income premium subsidy amount in the following year. If none are available, CMS will then assign to a PDP with a premium below de minimis in the same organization. If the organization has more than one such plan in that region, CMS will randomly reassign beneficiaries among those plans.

If the organization does NOT offer another plan in the same region that offers basic prescription drug coverage and has a premium at or below the low-income premium subsidy amount for the following year, CMS will randomly reassign affected beneficiaries to other PDP sponsors that have at least one PDP with a premium at or below the following year's low-income premium subsidy amount in that region.

C. CMS Notification to Beneficiaries

CMS will ensure that all beneficiaries being re-assigned are notified. These notices will instruct beneficiaries who are being reassigned because premium increase to contact their current plan if they wish to remain with the plan for the following year.

D. Plan Communication to Affected Beneficiaries

*"Losing" PDPs are responsible for sending an appropriate ANOC or its alternative (if the PDP is renewing in the following year), or termination notices (if the plan is terminating in the following year). (See **Exhibit 30**)*

*"Gaining" PDPs are responsible for providing enrollment confirmation (See **Exhibit 29**) and enrollment materials to beneficiaries in a timely manner.*

E. Plans That Keep LIS Assignees Because They are Below De Minimis

PDPs will keep their LIS assignees if:

- *the PDP's premium was at or below the de minimis amount in the current year and will not exceed the de minimis amount in the following year; and*
- *the benefit package continues to be basic.*

The premium amount charged to full premium subsidy beneficiaries will be equal to the subsidy amount. The plan will charge beneficiaries with a partial premium subsidy (i.e., 25%, 50% OR 75%) that percentage of the subsidy amount plus the amount by which the total Part D premium in the following year exceeds the subsidy amount. For example, if the premium is $102, and the low-income premium subsidy amount is $100, the plan will charge full premium subsidy (100%) beneficiaries $100 (which will be fully covered by the LIS). The plan will charge partial premium subsidy beneficiaries 25%, 50%, or 75% of $100 plus the $2 by which the Part D premium exceeds the subsidy amount ($27, $52, or $77).

Please Note: Plans that offer basic prescription drug coverage and have premiums above the "de minimis" amount will no longer receive new auto- or facilitated enrollments starting in October. This avoids the need to immediately reassign these beneficiaries to a different plan.

F. Requests for "Re-Enrollment" in the "Losing" Plan

*CMS' notices to affected beneficiaries will instruct them to contact their current plan if they wish to remain with the plan for the following year. If a reassigned beneficiary contacts the plan and indicates that s/he wishes to remain enrolled despite incurring premium liability, **the plan must take a new enrollment election** in accordance with §30.1.1 – 30.1.3 and §30.2 f.*

*As part of this enrollment, the plan must confirm and document the beneficiary's understanding of the financial liability s/he will incur by remaining with the plan for 2007. **However, DO NOT transmit these enrollment elections to CMS until a weekly***

Transaction Reply Report (TRR) is received confirming the beneficiary's disenrollment from the plan. *For the new enrollment, use the actual application date, which should be no earlier than November 15 of the current year; an election type of "S" (Special Enrollment Period), and an effective date of January 1 of the following year.*

G. "Gaining" PDPs

PDPs that qualify for auto- and facilitated enrollment with effective dates starting January 1 of the following year will also qualify to receive those LIS beneficiaries reassigned as described above. For re-assignment within the same PDP Sponsor, this includes those with premiums that will be below de minimis in the following year (if there are none below the low-income premium subsidy amount). Please note that beneficiaries will only be reassigned to plans offering basic prescription drug coverage, not employer/union sponsored or plans in the U.S. territories. In addition, qualifying PDPs must meet the "Requirements Critical for Ensuring Effective Enrollment of Dual Eligibles" issued August 31, 2006.

30.1.6 Group Enrollment for Employer/Union Sponsored PDPs

CMS will allow the employer or union *group* to enroll its retirees using a group enrollment process that includes providing CMS with any information it has on other insurance coverage for the purposes of coordination of benefits, as well as creditable coverage history it has on each beneficiary group enrolled for purposes of assessing the late enrollment penalty.

It is the PDP sponsor's responsibility to ensure the group enrollment process meets all applicable PDP enrollment requirements. PDP sponsors must ensure that contracts and other arrangements and agreements with employers and unions intending to use the group enrollment process make these requirements clear.

The group enrollment process must include notification *and materials* to each beneficiary as follows:

- All beneficiaries must be notified that the *employer/union* intends to enroll them in a PDP that the *employer/union* is offering; and
- That the beneficiary may affirmatively opt out of such enrollment; how to accomplish that; and any consequences to *employer/union* benefits opting out would bring; and
- This notice must be provided not less than *21* calendar days prior to the effective date of the beneficiary's enrollment in the group sponsored PDP.
- *Additionally, the notification materials provided must include a summary of benefits offered under the employer/union sponsored PDP, an explanation of how to get more information about the PDP, and an explanation on how to contact Medicare for information on other Part D options that might be available to the beneficiaries. Each individual must also receive the information contained on page 3 of Exhibit 1 of this guidance*

For enrollment processing purposes, the receipt date is the first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems..

The employer/group or union must provide all the information required for the PDP sponsor to submit a complete enrollment request transaction to CMS as described in this and other CMS Part D systems guidance. Refer to Appendix 2.

30.1.7 Enrollment for Beneficiaries in Qualified State Pharmaceutical Assistance Programs (SPAPs)

CMS will allow qualified SPAPs to submit mass enrollment requests in an agreed-upon electronic file format to PDPs in accordance with the following provisions:

- The SPAP must attest, as required by section 30.2.1 of this guidance that it has the authority under state law to enroll on behalf of its members.
- The SPAP must coordinate with the PDP to provide the required data elements for the plan to process and submit an enrollment request to CMS.
- The SPAP must provide a notice to its members in advance of submitting the requests that explains that the SPAP is enrolling on their behalf, how the enrollment works with the SPAP and how individuals can decline such enrollment.

In return, PDPs that agree to accept mass enrollments from SPAPs are required to process them like any other enrollment and in accordance with notification timeframes. It is important for the PDP sponsor to work with the contact at the SPAP in the event that the plan encounters any problems processing the enrollment request in the format provided. Because the SPAP is the authorized representative of the beneficiary, the plan is responsible for following up with the SPAP if the enrollment is incomplete in any way (to obtain missing information) or if the enrollment is conditionally rejected due to the existence of the employer/union drug coverage (to confirm that the individual understands the implications of enrolling in a Part D plan).

30.2 - *Processing* the Enrollment *Request*

If an enrollment request is completed during a face-to-face interview, the PDP sponsor should use the individual's Medicare card to verify the spelling of the name, and to confirm the correct recording of sex, Health Insurance Claim Number, and dates of entitlement to Medicare Part A and/or enrollment in Part B. If the form is mailed or faxed to the PDP sponsor, or for on-line or other enrollment processes, the PDP sponsor should verify this information with the individual via telephone or other means, or request that the individual include a copy of his/her Medicare card when mailing in the

enrollment request. The PDP sponsor may also access CMS systems to verify Medicare entitlement.

Appendix 2 lists all the elements that must be provided in order to consider the enrollment request complete. If the PDP sponsor receives an enrollment request that contains all these elements, the PDP sponsor must consider the enrollment request complete even if all other data elements on the enrollment request are not filled out. If a PDP sponsor has received CMS approval for an enrollment request vehicle that contains data elements in addition to those on the model paper enrollment form included in this guidance, then the enrollment request must be considered complete even if those additional elements are not filled in.

If a PDP sponsor receives an enrollment request that does not have all necessary elements required in order to consider it complete, it must not immediately deny the enrollment. Instead, the enrollment is considered incomplete and the PDP sponsor must follow the procedures outlined in §30.2.2 in order to complete the enrollment. *T*he PDP sponsor *must* check available *CMS* systems *(e.g. either the BEQ or MARx online query – M232 screen)* for information to complete an enrollment before requiring the beneficiary to provide the missing information. For example, if a beneficiary failed to fill out the "sex" field on the enrollment, the PDP sponsor could obtain this information via available systems rather than request the information from the beneficiary.

The following should also be considered when completing an enrollment:

A. Permanent Residence Information - The PDP sponsor must obtain the individual's permanent residence address to determine that he/she resides within the PDP plan's service area. If an individual puts a Post Office Box as his/her place of residence on the enrollment request, the PDP sponsor must consider the enrollment election incomplete and must contact the individual to determine place of permanent residence. If the applicant claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, the PDP sponsor should consult the State law in which the PDP sponsor operates and determine whether the enrollee is considered a resident of the State.

B. **Entitlement Information** ***– Following the procedures outlined in the CMS Plan Communications User Guide, PDP sponsors must verify Part D eligibility/Medicare entitlement by either the Batch Eligibility Query (BEQ) process or the MARx online query (M232 screen) for all enrollment requests.***

Individuals are not required to provide evidence of entitlement to Medicare Part A and/or enrollment in Part B with their enrollment request. If the systems (BEQ or MARx on-line query) indicate that the individual is entitled to Medicare Part A and/or enrolled in Part B, then no further documentation of Medicare entitlement from the individual is needed.

If neither the BEQ nor MARx online query (M232 screen) shows eligibility for Part D, the PDP organization may consider the individual's Medicare ID card as evidence of Medicare entitlement.

If the PDP sponsor is not able to verify entitlement through available systems or Medicare ID card, refer to §30.2.3 for additional procedures.

C. Effective Date of Coverage - The PDP sponsor must determine the effective date of enrollment as described in §20.4 for all enrollment requests. If the individual fills out an enrollment request in a face-to-face interview or through telephone enrollment, then the PDP sponsor representative may advise the individual of the proposed effective date, but must also stress to the individual that it is only a proposed effective date and that the individual will hear directly from the PDP sponsor to confirm the actual effective date of enrollment. The PDP sponsor must notify the member of the effective date of enrollment prior to the effective date (refer to §30.4 for more information and a description of exceptions to this rule).

If an individual submits an enrollment request with an unallowable effective date, or if the PDP sponsor allowed the individual to select an unallowable effective date, the PDP sponsor must notify the individual in a timely manner and explain that the enrollment must be processed with a different (allowable) effective date of enrollment. The organization should resolve the issue with the individual as to the correct effective date, and the notification must be documented. If the individual refuses to have the enrollment processed with the correct effective date, the beneficiary can cancel the enrollment according to the procedures outlined in §50.*1*.

For auto/facilitated enrollments, refer to section §30.1.4 of this guidance for more information.

D. Health Related Information - PDP sponsors may not ask health screening questions during the enrollment process.

E. Statement of Understanding and Release of Information - The PDP sponsor must include the information contained in **Exhibit 1** on page 3 under the heading "Please read and sign below" in all of its enrollment request vehicles.

Special Note for Part D Payment Demonstrations Plans Only:

In addition, Part D Payment Demonstrations must include the following statement in all enrollment requests:

"By joining this plan, I attest that I am not receiving any financial support from my current or former employer or union *group* (or my spouse's current or former employer/union *group*) intended for the purchase of prescription drugs or

prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare drug plan."

F. Signature and Date *on Paper Enrollment Forms* - When a paper enrollment form is used, the individual must sign the enrollment form. If the individual is unable to sign the form, a legal representative must sign the enrollment form (refer to §30.2.1 for more information). If a legal representative signs the form for the individual, then he or she must attest on the form that he or she has the authority under State law to effect the enrollment request on behalf of the individual and that a copy of the proof of other authorization required by State law that empowers the individual to effect an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Acceptable documentation includes items such as court-appointed legal guardianship or durable power of attorney.

The individual and/or legal representative should also write the date he/she signed the enrollment request; however, if he/she inadvertently fails to include the date on a paper enrollment form, or if an alternate enrollment mechanism is used, then the date of receipt that the PDP sponsor notes on the enrollment request will serve as the "signature date" of the request.

If a paper enrollment form is submitted and the signature is not included, the PDP sponsor may verify with the individual with a phone call and document the contact, rather than return the paper enrollment form as incomplete.

When an enrollment request mechanism other than paper is used, the individual or his or her legal representative must complete the enrollment mechanism process, including the attestation of legal representative status as described above. A pen-and-ink signature is not required.

G. Other Signatures - If the PDP sponsor representative helps the individual fill out the enrollment request, then the PDP sponsor representative must also sign the enrollment form and indicate his/her relationship to the individual. However, the PDP sponsor representative does not have to co-sign the form when:

- He/she pre-fills the individual's name and mailing address when the individual has requested that an enrollment form be mailed to him/her,
- He/she fills in the "office use only" block, and/or
- He/she corrects information on the enrollment form after verifying information (see "final verification of information" below).

The PDP sponsor representative does have to co-sign the form if he/she pre-fills any other information, including the individual's phone number.

H. Old Enrollment Requests- If the PDP sponsor receives an enrollment request that was completed more than 30 calendar days prior to the PDP sponsor's receipt of the request, the PDP sponsor is encouraged to contact the individual to re-affirm intent to enroll prior to processing the enrollment and to advise the beneficiary of the upcoming effective date.

I. **Determining the Application Date–** *T*he application date is the date the enrollment request is received by the PDP sponsor*, except for CMS On-line Enrollment Center requests, requests made by the group enrollment mechanism and auto or facilitated enrollments*. *I*f the request received is incomplete, follow the instructions provided in section 30.2.2 below.

The PDP sponsor must date as received all enrollment requests as soon as they are initially received by the PDP sponsor, as follows:

- For requests sent by mail, the *application* date is the date the application is received by the plan.
- For requests received by fax, the *application* date is the date the application is received on plan's fax machine.
- For requests made to/submitted to sales agents, including brokers, the *application* date is the date the agent/broker receives (accepts) the enrollment request. For purposes of enrollment, receipt by the agent or broker employed or contracting with the plan, is considered received by the plan.
- For requests accepted by approved telephonic enrollment mechanisms, the *application* date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and has been recorded.
- For requests made via the Medicare.gov Online Enrollment Center (OEC), the *application* date is the date CMS "stamps" on the enrollment request at the time the individual completed the OEC process. This true regardless of when a plan ultimately retrieves or downloads the request.
- For internet enrollment requests made directly to the plan's website, the *application* date is the date the request is completed through the plan's website process. This is true regardless of when a plan ultimately retrieves or downloads the request.
- *For group enrollments into employer or union sponsored plans, as described in §30.1.6, the application date will be first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems.*
- *For auto- or facilitated enrollment, as described in §30.1.4, the application date is first day of the month prior to the effective date of the auto/facilitated enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the auto- or facilitated enrollment in CMS systems.*

The date the enrollment request is received is the date that serves as the "application date" for purposes of submitting the enrollment to CMS *and determining the effective date*. If the enrollment form is not complete at the time it is received, follow the procedures in Section 30.2.2.

J. Correction of Information - The PDP sponsor may find that it must make corrections to an individual's enrollment request. For example, an individual may have made an error in writing his or her telephone number or may have transposed a digit in his or her date of birth. The PDP sponsor should make this type of correction to the enrollment request (e.g. the enrollment form) when necessary, and the individual making those corrections should place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, or an electronic record of a similar nature, may be used by the PDP sponsor (in place of the initialing procedure described in the prior sentence), and should become a part of the enrollment file. These types of corrections will not result in the PDP sponsor having to co-sign the enrollment form.

K. Sending the Enrollment to CMS – For all complete enrollment requests, the PDP sponsor must transmit the appropriate enrollment transaction to CMS within the time frames prescribed in §30.3, and must send the individual the information described in §30.4 within the required time frames. Processes for submitting transactions are provided in CMS systems guidance.

L. Premium withhold option

If the individual does not select a premium payment option, the default action will be direct bill. Currently, individuals have the option to have premiums withheld from their SSA benefit check. At this time, neither RRB nor OPM is able to process withhold requests.

30.2.1 - Who May Complete an Enrollment Request

A Medicare beneficiary is generally the only individual who may execute a valid enrollment request in, or disenrollment request from, a PDP. However, another individual could be the legal representative or appropriate party to execute an enrollment or disenrollment request as the law of the State in which the beneficiary resides may allow. The CMS will recognize State laws that authorize persons to effect a Part D enrollment or disenrollment request for Medicare beneficiaries. Persons authorized under State law may include court-appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have authority to act for the beneficiary in this capacity,

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request due to reasons such as physical limitations or illiteracy, State law would again govern

whether another individual may execute the request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a beneficiary, PDP sponsors should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

When someone other than the Medicare beneficiary completes an enrollment request, he or she must:

1) Attest that he or she has the authority under State law to make the enrollment request on behalf of the individual;
2) Attest that proof of authorization, if any, required by State law that empowers the individual to effect an enrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS. Plans cannot require such documentation as a condition of enrollment; and
3) Provide contact information.

Representative payee status, as designated by SSA, is not necessarily sufficient to enroll or disenroll a Medicare beneficiary. Where PDP sponsors are aware that an individual has a representative payee designated by SSA to handle the individual's finances, PDP sponsors should contact the representative payee to determine his/her legal relationship to the individual, and to ascertain whether he/she is the appropriate person, under State law, to execute the enrollment or disenrollment request.

30.2.2 - When the Enrollment Request Is Incomplete

When the enrollment request is incomplete, the PDP sponsor must document its efforts to obtain the missing information or documentation needed to complete the enrollment request. *The sponsor must make this determination and notify the individual within 10 calendar days of the receipt of the request that additional documentation is needed for the enrollment request.*

For AEP elections, additional documentation to make the request complete must be received by December 31, or within 21 calendar days (whichever is later). For all other enrollment periods, additional documentation to make the request complete must be received by the end of the month in which the enrollment request was initially received, or within 21 calendar days (whichever is later).
If additional documentation needed to make the request complete is not received within the timeframe above, the organization must deny the enrollment request using the procedures outlined in §30.2.3.

Requesting Information from the Beneficiary - To obtain information to complete the enrollment, the PDP sponsor must contact the individual to obtain the information *within 10 calendar days of receipt of the enrollment request (see Exhibit 3)*. If the contact is made orally (by phone), the PDP sponsor must document the contact and retain the documentation in its records. While CMS has provided a model notice, we would

encourage plans to obtain information by the most expedient means available. The PDP sponsor must explain to the individual that *if the information is not received within the timeframes described above,* the enrollment will be denied. If the PDP sponsor *denies the enrollment request, the sponsor* must provide the individual with a notice of denial of enrollment (see **Exhibit 6**).

If all documentation is received within allowable time frames and the enrollment request is complete, the PDP sponsor must transmit the enrollment to CMS within the time frames prescribed in §30.3, and must provide the individual with the information described in §30.4

30.2.3 - PDP sponsor Denial of Enrollment

A PDP sponsor must deny an enrollment *within 10 calendar days of receiving an enrollment request* based on (1) Its own determination of the ineligibility of the individual to elect the PDP plan (e.g. individual not having a valid enrollment period to elect a plan) and/or, (2) An individual not providing information to complete the enrollment request within the time frames described in §30.2.2.

PDP sponsor denials occur **before** the organization has transmitted the enrollment to CMS. For example, it may be obvious that the individual is not eligible to elect the plan due to place of residence. This "up-front" denial determination must be *within 10 calendar* days from the date of receipt of *an* enrollment request.

Notice Requirement - The organization must provide a notice of denial to the individual that includes an explanation of the reason for the denial *(see **Exhibit 6)**.*. This notice must be provided within *10 calendar days* of *either 1) receipt of the enrollment request or 2) expiration of the time frame for receipt of requested additional information, as described in the following examples:*
EXAMPLE

- A PDP sponsor receives an enrollment request from an individual on December 8[t]and determines on that same day that the individual is ineligible due to place of residence. The organization must provide the notice of denial within *10 calendar* days from December 8.

- *A PDP sponsor receives an enrollment form on December 8 from an individual, identifies the enrollment form as incomplete, and notifies the individual of the need for additional information, on December 10. The beneficiary does not submit the information by December 31 (as required under §30.2.2), which means the organization must deny the enrollment. The organization should send notice of denial within ten calendar days from December 31.*

30.3 - Transmission of Enrollments to CMS

For all enrollment requests *effective January 1, 2008, and after* that the organization is not denying per the requirements in §30.2.3, the PDP sponsor must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the PDP sponsor within *7* calendar days of receipt of the complete enrollment request.

All enrollment requests must be processed in chronological order by date of receipt of the enrollment request.

PDP sponsors are encouraged to submit transactions on a flow basis and as early as possible to resolve the many data issues that arise from late submissions. However, if the organization misses the cutoff date, it must still submit the transactions within the required *7*-day time frame.

NOTE: The *7*-day requirement to submit the transaction does not delay the effective date of the individual's enrollment in the PDP, i.e., the effective date must be established according to the procedures outlined in §20.4.

30.4 - Information Provided to Member

Much of the enrollment information that a PDP sponsor must provide to the enrolling individual must be provided prior to the effective date of enrollment. However, some information will be provided after the effective date of coverage.

As discussed previously (section 30), the PDP sponsor *must* provide *required* notices in response to *information received by CMS* on *the* TRR *that provides the earliest notification*. *In most instances, the weekly TRR will contain the earliest notification*

The PDP sponsor may provide the *required* notices *described* in §§ 30.4.1 and 30.4.2 in a single ("combination") notice *(see Exhibit 2b). To use the combination notice, the sponsor must be able to provide this notice* within *7 calendar* days of *availability* of the TRR. *Additionally, w*hen following this option *to use the combination notice*, if the PDP sponsor is *un*able to ensure that the beneficiary *will receive* this combination notice prior to the *enrollment* effective date *(*or within timeframes for *incomplete enrollment requests or* enrollments received at the end of the month*)*, the sponsor still must ensure that the beneficiary has the information required in § 30.4.1 within these timeframes *described therein*.

30.4.1 - Prior to the Effective Date of Enrollment

Prior to the effective date of enrollment, the PDP sponsor must provide the member with all the necessary information about being a Medicare member of the PDP, *including* the PDP rules, and the member's rights and responsibilities (*a*n exception to this requirement is described in §30.4.2.). *In addition, t*he PDP sponsor must provide the following to the individual:

- A copy of the completed enrollment form where applicable, if the individual does not already have a copy of the form;

- A notice acknowledging receipt of the enrollment request providing the expected effective date of enrollment (see **Exhibit 2**). This notice must be sent no later than *10 calendar* days after receipt of the enrollment *request*; and

Proof of health insurance coverage so that he/she may begin using the plan services as of the effective date. *This proof must include the 4Rx data necessary to access benefits.*

NOTE: This *proof of coverage* is not the same as the Evidence of Coverage document described in–CMS' marketing guidelines. Th*e proof of coverage provided* may be in the form of member *ID* cards, the enrollment form, and/or a notice to the member *(refer to Exhibit 2, which is a model letter with optional language that would allow the member to use the letter as proof of coverage until he/she receives a member card*.

Regardless of whether an enrollment request is made in a face-to-face interview, by fax, by mail, or by any other mechanism defined and allowed by CMS, the PDP sponsor must explain:

- The charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; (including general information about the low income subsidy).

- The prospective member's consent to the disclosure and exchange of necessary information between the PDP sponsor and CMS.

- The potential for member liability if it is found that the member is not eligible for Part D at the time coverage begins and the member has used PDP services after the effective date.

- The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the PDP sponsor has not yet provided the ID card).

Requirements for providing information to individuals enrolled via the auto-enrollment and facilitated processes are outlined §30.1.4.

30.4.2 - After the Effective Date of Coverage

CMS recognizes that for some enrollment requests, the PDP sponsor will be unable to provide the materials to the individual*, including notification of the effective date,* prior to the effective date, as generally required in §30.4.1. These cases will usually only occur *when an enrollment request is received by the PDP sponsor* in the last few days of a

month, and the effective date is the first of the upcoming month. In these cases, the PDP sponsor *still* must provide the individual all materials described above no later than *10 calendar* days after receipt of the enrollment request. In these cases, the PDP sponsor is also strongly encouraged to call the*se new* member*s as soon as possible (such as* within 1 *- 3 calendar* day*s)* to provide the effective date, information to access benefits and explain the PDP rules.

Acceptance/Rejection of Enrollment - Once the PDP sponsor receives a reply listing report from CMS indicating whether the individual's enrollment has been accepted or rejected, the PDP sponsor must notify the individual of CMS' acceptance or rejection of the enrollment within *10 calendar* days of the availability of the *weekly or monthly transaction* reply *report, whichever contains the earliest notification of the acceptance/rejection* (see **Exhibits 4 and 7**). *The enrollment confirmation notice must explain the charges for which the prospective member will be liable, e.g., any premiums, coinsurance, fees or other amounts; and any amount that is attributable to the Medicare deductible and coinsurance. For those eligible for the low-income subsidy, the enrollment confirmation notice must specify the limits applicable to the level of subsidy to which the person is entitled.*

There are exceptions *to this notice requirement for certain types of transaction rejections*, so as not to penalize the beneficiary for a systems issue or delay, such as plan transmission error or when the organization receives the initial CMS reply listing that rejects the individual's enrollment due to no Medicare Part A and/or no Medicare Part B but the PDP sponsor has evidence to the contrary. In this case, the PDP sponsor must request a retroactive enrollment correction from CMS (or its designee) within 45 days from the availability of the initial *transaction reply report*. If *CMS (or its designee)* is unable to process the enrollment correction due to its determination that the individual indeed does not have Medicare Part A or Part B, the PDP sponsor must reject the enrollment and must notify the individual of the rejection within *10 calendar* days *after CMS' (or its designee's)* determination. Retroactive enrollments are covered in more detail in §*50.3*.

If a PDP sponsor rejects an enrollment request *and later* receives additional information from the individual showing entitlement to Medicare Part A and/or enrollment in Part B, the PDP sponsor must obtain a new enrollment request from the individual in order to enroll the individual, and must process the enrollment with a current (i.e., not retroactive) effective date. Refer to §50.3 for more information regarding retroactive enrollments and the 45-day requirement.

30.5 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive action may be necessary (refer to §§50.3 and 50.5 for more information). In addition, a reinstatement to the plan in which the individual was originally enrolled may be necessary if the invalid enrollment resulted in an individual's disenrollment from his/her original plan of choice.

An enrollment that is not complete is not legally valid. In addition, an enrollment is not legally valid if it is later determined that the individual did not meet eligibility requirements at the time of enrollment. For example, an enrollment is not legally valid if a PDP sponsor or CMS determines at a later date that an incorrect permanent address was provided at the time of enrollment and the actual permanent address is outside the PDP's service area.

There are also instances in which an enrollment that appears to be complete can turn out to be legally invalid. In particular, CMS does not regard an enrollment as actually complete if the individual, or his/her legal representative, did not intend to enroll in the PDP. If there is evidence that the individual did not intend to enroll in the PDP, the PDP sponsor should submit a retroactive disenrollment request to the CMS (or its designee). Evidence of lack of intent to enroll by the individual may include:

- An enrollment request signed by the individual when a legal representative should be signing;

- Request by the individual for cancellation of enrollment before the effective date (refer to §50.1.1 for procedures for processing cancellations);

Payment of the premium does not necessarily indicate an informed decision to enroll. For example, the individual may believe that he/she was purchasing a supplemental health insurance policy, as opposed to enrolling in a PDP.

40 - Disenrollment Procedures

Except as provided for in this section, a PDP sponsor may not, either orally or in writing or by any action or inaction, request or encourage any enrollee to disenroll from a PDP. While a PDP sponsor may contact members to determine the reason for disenrollment, the PDP sponsor must not discourage members from disenrolling after they indicate their desire to do so. The PDP sponsor must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

All notice requirements are summarized in **Appendix 1.** The PDP sponsor must provide disenrollment notices in response to transaction replies received from CMS based upon the monthly transaction reply report (TRR).

40.1 - Voluntary Disenrollment by an Individual

A member may only disenroll from a PDP plan during one of the periods outlined in §§20.2 and 20.3. The member may disenroll by:

1. *Enrolling in another plan (during a valid enrollment period);*

2. Giving or faxing a signed written notice to the PDP sponsor, or through their employer/union *group*, where applicable;

3. Submitting a request via Internet to the PDP sponsor (if the PDP sponsor offers such an option);

4. Calling 1-800-MEDICARE.

If a member verbally requests disenrollment from the PDP, the PDP sponsor must instruct the member to make the request via one of the 3 processes outlined above. The PDP sponsor may send a disenrollment form to the member upon request (see **Exhibits 8 and 9**).

The disenrollment request must be dated when it is received by the PDP sponsor.

When someone other than the Medicare beneficiary completes a disenrollment request, he or she must:

1) Attest that he or she has the authority under State law to make the disenrollment request on behalf of the individual;
2) Attest that proof of this authorization (if any), as required by State law that empowers the individual to effect a disenrollment request on behalf of the applicant is available upon request by the PDP sponsor or CMS; and
3) Provide contact information.

40.1.1 - Requests Submitted via Internet

The PDP sponsor has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The PDP sponsor must, at a minimum, comply with the CMS internet architecture requirements - found at http://www.cms.hhs.gov/it/enterprisearchitecture/default.asp. The PDP sponsor may also include additional security provisions.

The CMS reserves the right to audit the PDP sponsor to ascertain whether it is in compliance with the security policy.

40.1.2 - Request Signature and Date

When requesting voluntary disenrollment by submitting a written request, the individual must sign the disenrollment request. If the individual is unable to sign, a legal representative must sign the request (refer to §30.2.1 for more detail on who may

complete enrollment and disenrollment requests). *If the request is not signed, see section 40.4.2 for information to complete the disenrollment request.*

The individual and/or legal representative should write the date he/she signed the disenrollment request; however, if he/she inadvertently fails to include the date, then the date of receipt that the PDP sponsor places on the request form will serve as the application receipt date.

40.1.3 - Effective Date of Disenrollment

The enrollment/disenrollment period during which a valid request to disenroll was received by the PDP organization will determine the effective date of the disenrollment request; refer to §20.5 for information regarding disenrollment effective dates.

With the exception of some SEPs and when periods overlap, individuals may not choose the effective date of disenrollment. Instead, the PDP sponsor is responsible for assigning the appropriate effective date based on the enrollment period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the PDP sponsor staff are responsible for ensuring that a beneficiary does not attempt to choose an effective date that is not allowed under the requirements outlined in §20.5.

If an individual submits a disenrollment request with an unallowable effective date, the PDP sponsor must contact the beneficiary to explain that the disenrollment must be processed with a different effective date. The organization should resolve the issue with the beneficiary as to the correct effective date, and the contact must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary may cancel the disenrollment according to the procedures outlined in §50.2.2 prior to the effective date.

40.1.4 – PDP Sponsor Denial of Voluntary Disenrollment Request

If the PDP sponsor receives a disenrollment request that it must deny, the PDP sponsor must notify the enrollee within *10 calendar* days of the receipt of the request, and must include the reason for the denial (**see Exhibit 6**).

A PDP sponsor may only deny a voluntary request for disenrollment when:

1. The request was made outside of an allowable period as described in §20 of this guidance; or
2. The request was made by someone other than the enrollee and that individual is not the enrollee's legal representative (as described in §30.2.1).

40.1.5 - Notice Requirements

After the member submits a disenrollment request, the PDP sponsor must provide the individual a disenrollment notice within *10 calendar* days of receipt of the request to

disenroll (see **Exhibit 10**). The disenrollment notice must include an explanation that the individual remains enrolled in the PDP until the effective date of the disenrollment. For these types of disenrollments, i.e., disenrollments in which the individual has disenrolled directly through the PDP sponsor, PDP sponsors are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the reply listing.

Since Medicare beneficiaries have the option of disenrolling through 1-800-MEDICARE, or by enrolling in another Part D plan, the PDP sponsor will not always receive a request for disenrollment directly from the individual but will instead learn of the disenrollment through the CMS Reply Listing Report. If the PDP sponsor learns of the disenrollment from the CMS reply listing (as opposed to through the receipt of a request from the enrollee), the PDP sponsor must send a notice of confirmation of the disenrollment to the individual within *10 calendar* days of the availability of the reply listing (see **Exhibit 10a**).

For a PDP sponsor denial of voluntary disenrollment as described in §40.1.4, the denial notice must be sent within *10 calendar* days of the denial determination and must include the reason for denial (see **Exhibit 11**).

40.2 - Required Involuntary Disenrollment

A PDP organization must disenroll an individual from a PDP in the following cases.

1. A change in residence (including incarceration) making the individual ineligible to be an enrollee of the PDP (§40.2.1)

2. The individual loses entitlement to Medicare (§40.2.2.);

3. The individual dies (§40.2.3); or

4. The PDP contract is terminated, or the PDP organization discontinues offering a PDP in any portion of the area where the PDP had previously been available (§40.2.4); or

5. The individual materially misrepresents information to the PDP organization regarding reimbursement for third-party coverage (§40.2.5).

40.2.1 - Individuals Who Change Residence

The PDP sponsor must disenroll an individual when an individual (or legal representative) notifies the PDP that he or she no longer resides in the service area of a PDP. The PDP sponsor must retain documentation of the permanent change of address and disenroll the individual. If the PDP sponsor offers another PDP in the region in which the beneficiary resides, the sponsor may use this opportunity to inform the beneficiary of its other PDP product(s).

If the PDP sponsor learns of a beneficiary address change that is outside the PDP service area from either CMS (i.e. a state and county code change on the transaction reply report) or from the U.S. Postal Service (USPS), it must follow the "Researching and Acting on a Change of Address" procedures outlined below.

An SEP, as defined in §20.3.1, applies to individuals who are disenrolled due to a change in residence. An individual may choose another Part D plan (either a PDP or MA-PD) during this SEP.

Researching and Acting on a Change of Address

When a PDP sponsor receives information from either CMS or the USPS that a beneficiary no longer resides in the service area, a PDP sponsor must make an attempt to contact the member to confirm whether the move is permanent and document its efforts in doing so. *In the case of incarcerated individuals, the PDP may confirm the individual's out-of-area (i.e. incarcerated) status with public sources (such as a state/federal government entity or other public records) rather than direct contact with the individual.* The PDP sponsor may obtain either written or verbal verification of changes in address, as long as the PDP sponsor applies the policy consistently among all members.

If the PDP sponsor does not receive confirmation from the member (or his or her legal representative) within a six month period, the PDP sponsor must initiate disenrollment. The six month period will begin on the date the change of address is identified (e.g. through the transaction reply report or forward address notification from the USPS).

When researching changes of address, CMS encourages plans to utilize resources available to them, including any CMS systems interfaces, use internet search tools, address information from provider claims, etc.

Special Procedures for Auto and Facilitated Enrollees Whose Address Is Outside the PDP Region:

If PDP sponsor discovers that an individual who CMS had auto-enrolled has an address outside of the PDP sponsors' region via a state and county code change on the transaction reply report or the USPS, the PDP sponsor must make an attempt to confirm whether the

move is permanent and document its efforts in doing so. The PDP sponsor may obtain either written or verbal verification of changes in address, as long as the PDP sponsor applies the policy consistently among all members.

If the sponsor confirms **the move is temporary**, the PDP sponsor must retain the individual as a member.

If the sponsor confirms **the move is permanent** and has a PDP in the new region that offers a basic benefit package (i.e. other than enhanced) with a premium at or below the low-income premium subsidy amount for that region, then the PDP organization may submit an enrollment transaction to enroll the beneficiary in that PDP prospectively. (**See Exhibit 27**).

If the sponsor confirms **the move is permanent** and does not have a PDP in the new region that offers a basic benefit package with a premium at or below the low-income premium subsidy amount for that region, the PDP sponsor must inform the beneficiary that s/he must enroll in a PDP that serves the area where s/he now resides and proceed with the disenrollment, effective the first of following month. (**See Exhibit 28**).

If the PDP sponsor is unable to contact the beneficiary, or receives no response, within a six month period, the PDP sponsor must initiate disenrollment. The six month period will begin on the date the change in address is identified (e.g. through the transaction reply report).

Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable

If an address is not current, the USPS will return any materials mailed first-class by the sponsor as undeliverable.

> *Note: For auto and facilitated enrollees, CMS provides PDP sponsors with mailing addresses as maintained in CMS systems. These addresses are not always current, and in cases where the beneficiary has a representative payee, the address of the payee will be the address of record in CMS systems.*

In the event that any member materials are returned as undeliverable, the PDP sponsor must take the following steps:

1. If the USPS returns mail with a new forwarding address, forward plan materials the beneficiary and advise the plan member to change his or her address with the Social Security Administration.

2. If the PDP receives documented proof from the USPS of a beneficiary change that is outside of the PDP region or mail is returned without a forwarding address, follow the procedures outlined above.

3. If the beneficiary uses his or her drug coverage at a pharmacy in the plan's network, the sponsor may choose to follow up with the pharmacy to obtain the member's current address.

4. If the beneficiary is located, advise the beneficiary to update records with the Social Security Administration by:
    a. Calling their toll-free number, 1-800-772-1213. TTY users should call 1-800-325-0778 weekdays from 7:00 a.m. to 7:00 p.m. EST;
    b. Going to http://www.ssa.gov/changeaddress.html on the SSA website; or
    c. Notifying the local SSA field office. A beneficiary can get addresses and directions to SSA field offices from the Social Security Office Locator which is available on the Internet at: http://www.socialsecurity.gov/locator.

A PDP sponsor is expected to continue to research addresses as described in the "Researching and acting on change of address" above.

Effective Date

Disenrollment is effective on the first of the month following the month in which the individual (or his or her legal representative) provides notice of the permanent move to the PDP organization. However, in the case of an individual who provides advance notice of the move, the disenrollment may be the first of the month following the month in which the individual indicates he/she will be moving.

Disenrollment as a result of receiving information from either CMS or the U.S. Post Office that the individual has not confirmed will be effective the first day of the calendar month after 6 months have passed.

Notice Requirement –

1. **PDP sponsor notified of out-of-area permanent move -** When the PDP sponsor receives notice of a permanent change in address from the individual, it must provide notification of disenrollment to the member. This notice must be provided within *10 calendar* days of the PDP sponsor's learning of the permanent move before the disenrollment transaction is submitted to CMS.

2. **Out of area for 6 months -** .When the individual has been out of the service area for 6 months after the date the PDP sponsor learned of the change in address from either CMS or the USPS and the sponsor has not be able to obtain confirmation, the PDP sponsor must provide notification of the upcoming disenrollment to the individual.

    The notice of disenrollment must be provided some time during the 6th month, or no later than *10 calendar* after the 6th month as long as the notice is provided before the disenrollment is submitted to CMS. The notice should advise the

member to notify the PDP sponsor as soon as possible if the information is incorrect.

40.2.2 - Loss of Entitlement to Medicare Part A or Part B

An individual who is no longer entitled to either Medicare Part A and/or Part B benefits may not remain enrolled in a PDP. The organization will be notified by CMS that entitlement to Medicare Part A and/or Part B has ended, and CMS will make the disenrollment effective the first day of the month following the last month of entitlement to Medicare Part A and/or Part B benefits.

Notice Requirements – Notice must be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see **Exhibit 12**) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §50.2.1.

40.2.3 - Death

CMS will disenroll an individual from a PDP sponsor upon his/her death and CMS will notify the PDP organization that the individual has died. This disenrollment is effective the first day of the calendar month following the month of death.

Notice Requirements - *Organizations may not submit disenrollment transactions to CMS in response to the apparent death of a member. In the anticipation at official notification from CMS via the TRR, the organizations may, at their discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices. Following the receipt of a CMS notification (via TRR) of disenrollment due to death,* a notice must be sent to the member or the estate of the member (see **Exhibit 13**) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, refer to §50.2.1.

40.2.4 - Terminations/Nonrenewals

The PDP organization must disenroll an individual from a PDP if the PDP contract is terminated, or if the PDP organization discontinues offering the PDP or non-renews the PDP in any portion of the area where the PDP had previously been available.

An individual who is disenrolled under these provisions has an SEP, as described in §20.4.3, to enroll in a different PDP.

Notice Requirements - The PDP sponsor must give each Medicare individual a written notice of the effective date of the termination, and include a description of alternatives for obtaining benefits under the Medicare program. CMS will provide further guidance to affected sponsors, as required by 42 CFR 423.507 - 423.509.

40.2.5 – Material Misrepresentation Regarding Third-Party Reimbursement

If a PDP enrollee intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires that the individual be disenrolled from the PDP. Involuntary disenrollment for this reason requires CMS approval. The PDP sponsor must submit any information it has regarding the claim of material misrepresentation to its CMS account manager for review. Disenrollment for material misrepresentation of this information is effective the first of the month following the month in which the enrollee is notified of the disenrollment, or as CMS specifies.

40.3 - Optional Involuntary Disenrollments

A PDP sponsor may disenroll a member from a PDP it offers if:

- Premiums are not paid on a timely basis (§40.3.1);
- The member engages in disruptive behavior (§40.3.2); or
- The member provides fraudulent information on an enrollment request, or if the member permits abuse of an enrollment card in the PDP (§40.3.3).

Notice Requirements - In situations where the PDP sponsor disenrolls the member involuntarily for any of the reasons addressed above, the PDP sponsor must send notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that the PDP sponsor is planning to disenroll the member and why such action is occurring;
- Provides the effective date of termination; and
- Includes an explanation of the member's right to a hearing under the PDP sponsor's grievance procedures.

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

40.3.1 - Failure to Pay Premiums

PDP sponsors may not disenroll a member who fails to pay PDP cost sharing under this provision. However, a PDP sponsor has two options when a member fails to pay the PDP's premiums.

For each of its PDPs, the PDP sponsor must take action consistently among all members, i.e., a PDP sponsor may have different policies among its different PDPs, but it may not have different policies within a PDP.

The PDP sponsor may:

1. Do nothing, i.e., allow the member to remain enrolled in the same PDP;

2. Disenroll the member after a grace period and proper notice.

If the PDP sponsor chooses to disenroll the member, this action may only be accomplished by the PDP sponsor after the sponsor makes a reasonable attempt to collect the payment *and notice has been provided to the member (as described below)*. If payment has not been received within a grace period, the individual will be disenrolled.

*Sponsors **may not** disenroll members for failure to pay premiums (or notify them of impending disenrollment) in cases where the member has requested that premiums be withheld from his/her Social Security benefit check until the sponsor receives a reply from CMS indicating that the member's request has been rejected. The sponsor must then notify the member of the premium owed, provide the appropriate grace period, and comply with other applicable requirements prior to disenrolling the member.*

Sponsors may not involuntarily disenroll any individuals who are considered to be in premium withhold status by CMS. *Individuals who have requested premium withhold are considered to remain in premium withhold status until either (1) CMS notifies the sponsor that the premium-withhold request has rejected, failed, or been unsuccessful; or (2) the member requests that he/she be billed directly. Only after one of these actions occurs may a member's status be changed to "direct bill." Once the member is considered to be in "direct bill" status, the sponsor must notify the member of the premium owed and provide the appropriate grace period, as described below. Sponsors must always provide members the opportunity to pay premiums owed before initiating any disenrollment action.*

However, even if a member's premium payment status has been changed to "direct bill" and the member can demonstrate that SSA has withheld Part C and/or Part D premiums during the coverage month(s) in question, the member will be considered to remain in premium withhold status.

> ***Example 1 – Incorrect Continuation of Premium Withhold:*** *Individual was enrolled in Plan A and selected premium withhold. Individual subsequently enrolls in Plan B and does not select premium withhold. Upon receiving a direct bill from Plan B, the individual provides Plan B with proof that a premium deduction continues from his SSA benefit check. Since the member provided Plan B with evidence that a premium amount is currently being deducted from his check, Plan B cannot initiate the process to disenroll the individual for failure to*

pay premiums. Plan B must work with CMS to obtain appropriate premium reimbursement.

Further, an individual will continue to be considered in premium withhold status if a plan is notified by CMS that the member's request for premium withholding is not successful as a result of systems/fund transfer issues between CMS and the Social Security Administration (SSA), or between CMS and the plan. CMS recognizes that in some instances plans have not received premium amounts in their monthly CMS plan payment for members who have elected Social Security withholding; however, organizations and sponsors cannot hold their members responsible for such issues, nor penalize them by attempting to disenroll them from their plan. Therefore, the plan ***may not*** *initiate the billing (and subsequent disenrollment process, if necessary) until a member is in "direct bill" status.*

> ***Example 2:*** *An individual requests premium withhold and Plan A correctly submits the request to CMS. The transaction request is submitted successfully by CMS to SSA and the appropriate premium amount is deducted from the individual's SSA benefit check. However, due to a systems issue between CMS and SSA, the premium withhold data is not correctly reflected in CMS systems. Thus, CMS does not pay the correct premium amount to Plan A. Plan A must work with CMS to obtain appropriate premium reimbursement and may not initiate the disenrollment process for the individual for failure to pay premiums while the deduction continues to be withheld.*

CMS reminds organizations and sponsors that they ***may not*** *disenroll a member or initiate the disenrollment process if the plan has been notified that a State Pharmaceutical Assistance Program (SPAP) or other payer intends to pay the entire Part D premium on behalf of an individual. (Section 50.6 of Chapter 14 of the PDP Manual.)*

While the PDP sponsor may accept partial payments, it has the right to ask for full payment within the grace period. If the member does not pay the required amount within the grace period, the effective date of disenrollment is the first day of the month after the grace period ends. **The PDP sponsor has the right to take action to collect the unpaid premiums from the beneficiary at any point during or after this process.**

If a member is disenrolled for failure to pay premiums and attempts to re-enroll in the organization, the PDP sponsor may require the individual to pay any outstanding premiums owed to the PDP sponsor before accepting the enrollment.

If the individual is involuntarily disenrolled for failure to pay premiums, in order to re-enroll in that plan, or to enroll in another, the individual must request enrollment during a valid period.

Calculating the Grace Period

A PDP sponsor must provide plan enrollees with a grace period of not less than 1 calendar month, however it may provide a grace period that is longer than 1 month, at its discretion.

The **grace period** must be a minimum of 1 calendar month that begins on the 1st day of the month on or after the due date for the unpaid premium amount. However, the grace period cannot begin until the individual has been notified of//billed for the actual premium amount due, with such notice/bill specifying the due date for that amount and provided an opportunity to pay. For new enrollees, a PDP sponsor must wait until notified by CMS of the actual premium which the beneficiary is responsible for paying directly before the individual can be notified of/billed for the amount due; for these individuals, the due date cannot be until after the sponsor receives notification from CMS as to the beneficiary's premium and notifies the individual of the amount due. The grace period can then begin no earlier than the first day of the month on or after the due date.

PDP sponsors have the following options in calculating and applying the grace period. The organization must apply the same option for all members of a plan.

Option 1 - PDP sponsors may consider the grace period to end not less than 1 calendar month after the first day of the month for which premium is unpaid.

If the overdue premium and all other premiums that become due during the grace period (in accordance with the terms of the member's agreement with the PDP sponsor) are not paid in full by the end of the grace period, the PDP sponsor may terminate the member's coverage.

As mentioned previously, the individual must be notified/billed of the actual premium amount due before the premium can be considered "unpaid." For new enrollees, at a minimum, this cannot occur until CMS notifies the PDP sponsor of the total premium due from the individual. Upon CMS notification, the PDP sponsor would bill the individual of the amount due, with a prospective due date.

Under this scenario, PDP sponsors are encouraged to send subsequent notices as reminders or to show that additional premiums are due. Subsequent notices, therefore, should determine the expiration date of the grace period by reference to this date. Notice requirements are summarized in this section under the heading "notice requirements."

Example A: Plan XYZ has a 1-month grace period for premium payment. Plan member Mr. Stone's premium was due on February 1, 2006. He did not pay this premium and on February 7th , the PDP sponsor sent an appropriate notice. Mr. Stone ignores this notice and any subsequent premium bills. The grace period is the month of February. If Mr. Stone does not pay his plan premium before the end of February, he will be disenrolled as of March 1, 2006.

Example B: Plan QRS has a 2-month grace period for premium payment. Plan member Mrs. Monsoon's premium was due on July 1, 2006. She did not pay this premium and on July 6th, the PDP sponsor sent an appropriate notice. Mrs. Monsoon ignores this notice and subsequent premium bills. The grace period is the months of July and August. If Mrs. Monsoon does not pay her premiums in full by the end of this period (August 31st), she will be disenrolled effective September 1, 2006.

The PDP sponsor must state that it requires the member to make full payment within the grace period, and pay all premiums falling due within that period, in its initial delinquency notice to the member if it chooses this policy.

Option 2 - PDP sponsors may use a "rollover" approach in applying the grace period.

Under this scenario, the grace period would begin on the first of the month for which the premium is unpaid, but if the member makes a premium payment within the grace period, the grace period stops, and the PDP sponsor would then send another notice informing the member of any overdue payments. The member would then have a new grace period beginning on the 1st day of the next month for which the premium is unpaid. This process would continue until the member's balance for overdue premiums was paid in full or until the grace period expired with no premium payments being made, at which time the PDP sponsor could terminate (or reduce, if applicable) the member's coverage.

EXAMPLE

Plan WXY has decided to offer a 2 –month grace period for non-payment of PDP premiums and has chosen the "rollover" approach to calculating the grace period. A member fails to pay his January premium due January 1. The PDP sponsor sends a notice to the member on January 7th stating that his coverage will be terminated if the outstanding premium is not paid within the grace period. The notice advises him that his termination date would be March 1. The member fails to pay his February premium, and receives a second notice from the PDP sponsor on February 9th. The member then pays the January premium, but does not pay the February premium. The grace period is recalculated to begin on the 1st of the next month for which the premium is unpaid (February 1). The PDP sponsor sends a notice to the member reflecting the new grace period, and the new anticipated termination date of April 1st. The member pays off his balance in full before the grace period expires, therefore the member's coverage in the PDP remains intact.

Notice Requirements - If the PDP sponsor chooses to disenroll the member when a member has not paid PDP premiums, the PDP sponsor must send an appropriate written notice *(see **Exhibit 19**)* to the member *as follows:*

- *If the PDP sponsor has a grace period of 1 calendar month, the PDP sponsor must send a notice of non-payment of premiums **within** 10 calendar days after the premium due date.*

- *If the PDP sponsor has a grace period of 2 or more months, the PDP sponsor must send this notice of non-payment of premiums **within** 15 calendar days after the premium due date.*

The PDP sponsor may send interim notices after the initial notice.

In addition to the notice requirements outlined in §50.3, this notice must:

- Alert the member that the premiums are delinquent, and;
- Provide the member with an explanation of disenrollment procedures advising the member that failure to pay the premiums within the grace period that began on the 1st of the month for which premium was unpaid will result in termination, and the proposed effective date of this action;
- Explain whether the PDP sponsor requires full payment within the grace period (including the payment of all premiums falling due during the intervening days, when and as they become due, according to the terms of the membership agreement) in order to avoid termination.

If a member does not pay within the grace period, and the PDP sponsor's policy is to disenroll the member, the PDP sponsor must notify the member in writing after the expiration of the grace period and prior to submission of the transaction to CMS that the PDP sponsor is planning on disenrolling him/her and provide the effective date of the member's disenrollment (see **Exhibit 20**). In addition, the PDP sponsor must send final confirmation of disenrollment to the member *within 10 calendar days of* receiving the reply listing report to ensure the individual does not continue to access PDP sponsor services (see **Exhibit 21**).

Optional Exception for Individuals *who Qualify for Low Income Subsidy (LIS)*

PDP sponsors have the **option** to retain *individuals who qualify for the low income subsidy* who fail to pay premiums even if the PDP sponsor has a policy to disenroll members for non-payment of premiums.

The PDP sponsor has the discretion to offer this option *to individuals who qualify for the low income subsidy* within each of its PDPs. If the PDP sponsor offers this option in one of its PDPs, it must apply the policy to all *such individuals* in that PDP.

Members of a PDP must be informed at least 30 *calendar* days before a policy changes within the plan. PDP sponsors will have the discretion as to how it will notify its members of the change, e.g. in an upcoming newsletter or other member mailing, such as the Annual Notice of Change. CMS recommends a general statement in such notifications to avoid confusing other members for whom the policy does not apply.

Example: "If you receive *have Medicaid or extra help in paying for your Medicare prescription drugs* and are having difficulty paying your plan premiums or cost sharing, please contact us."

The plan must document this policy internally and have it available for CMS review.

40.3.2 - Disruptive Behavior

The PDP sponsor **may** disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the PDP substantially impairs the PDP sponsor's ability to arrange for or provide services to either that particular member or other members of the PDP. However, the PDP sponsor may only disenroll a member for disruptive behavior after it has met the requirements of this section and with CMS' approval. The PDP sponsor may not disenroll a member because he/she exercises the option to make treatment decisions with which the PDP sponsor disagrees. The PDP sponsor may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the PDP sponsor or any health care professionals associated with the PDP sponsor.

Before requesting CMS' approval of disenrollment for disruptive behavior, the PDP sponsor must make a serious effort to resolve the problems presented by the member. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The PDP sponsor must also inform the individual of his or her right to use the organization's grievance procedures.

The PDP sponsor must submit documentation of the specific case to CMS for review. This includes documentation:

- Of the disruptive behavior;
- Of the PDP sponsor's serious efforts to resolve the problem with the individual;
- Of the PDP sponsor's effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances cited under 42 CFR §423.44(d)(2)(iii) and (iv);
- That the PDP sponsor provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and

- That the PDP sponsor then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).

The PDP sponsor must submit to the CMS Regional Office:

- The above documentation;
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the PDP sponsor's ability to arrange for or provide services to the individual or other members of the PDP;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member.
- The PDP sponsor may request that CMS consider prohibiting re-enrollment in the PDP (or PDPs) offered by the PDP sponsor in the service area.

The PDP sponsor's request for involuntary disenrollment for disruptive behavior must be complete, as described above. The CMS Regional Office will review this documentation and consult with CMS Central Office (CO), including staff with appropriate clinical or medical expertise, and decide whether the organization may involuntarily disenroll the member. Such review will include any documentation or information provided either by the organization and the member (information provided by the member must be forwarded by the organization to the CMS RO). CMS will make the decision within 20 business days after receipt of all the information required to complete its review. CMS will notify the PDP sponsor within 5 (five) business days after making its decision.

The Regional Office will obtain Central Office concurrence before approving an involuntary disenrollment. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment, or as provided by CMS.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the PDP sponsor to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable accommodation in this context is that CMS could require the PDP sponsor to delay the effective date of involuntary disenrollment to coordinate with an enrollment period that would permit the individual an opportunity to obtain other coverage. If necessary, CMS will establish an SEP on a case-by-case basis.

Notice Requirements

The disenrollment for disruptive behavior process requires 3 (three) written notices:

- Advance notice to inform the member that the consequences of continued disruptive behavior will be disenrollment;
- Notice of intent to request CMS' permission to disenroll the member; and
- A planned action notice advising that CMS has approved the PDP sponsor's request.

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the PDP sponsor must provide the member with written notice explaining that his/her continued behavior may result in involuntary disenrollment, and that cessation of the undesirable behavior may prevent this action. The notice must also inform the individual of his or her right to use the organization's grievance procedures. The PDP sponsor must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS. **NOTE:** If the disruptive behavior ceases after the member receives notice and then later resumes, the PDP sponsor must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the PDP sponsor's efforts, then the PDP sponsor must notify him/her of its intent to request CMS' permission to disenroll him/her for disruptive behavior. This notice must also advise the member of his/her right to use the organization's grievance procedures and to submit any information or explanation. The PDP sponsor must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS.

Planned Action Notice

If CMS permits a PDP sponsor to disenroll a member for disruptive behavior, the PDP sponsor must provide the member with a written notice that contains, in addition to the notice requirements outlined in §40.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above. The PDP sponsor may only provide the member with this required notice after CMS notifies the PDP sponsor of its approval of the request.

The PDP sponsor can only submit the disenrollment transaction to CMS after providing the notice of disenrollment (Planned Action Notice) to the individual. The disenrollment is effective the first day of the calendar month after the month in which the PDP sponsor gives the member a written notice of the disenrollment, or as provided by CMS.

40.3.3 - Fraud and Abuse

A PDP sponsor may disenroll a member who knowingly provides fraudulent information on the enrollment request that materially affects the member's eligibility to enroll in the plan. The sponsor may also disenroll a member who intentionally permits others to use his/her enrollment card to obtain services or supplies from the plan or any authorized plan provider. Such a disenrollment is effective the first day of the calendar month after the month in which the sponsor gives the member the written notice.

When such a disenrollment occurs, the sponsor must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

Notice Requirements - The PDP sponsor must give the member a written notice of the disenrollment that contains the information required at §40.3.

40.4 - Processing Disenrollments

Procedures for processing voluntary and involuntary disenrollments are described below.

40.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from an enrollee, the PDP sponsor is responsible for submitting disenrollment transactions to CMS in a timely, accurate fashion. Such transmissions *for disenrollment requests effective January 1, 2008 and after* must occur within *7* calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The PDP sponsor must maintain a system for receiving, controlling, and processing voluntary disenrollments from the PDP sponsor. This system should include:

- Dating each disenrollment request as of the date it is received (regardless of whether the request is complete at the time it is received by the PDP sponsor) to establish the date of receipt;
- Dating supporting documents for disenrollment requests as of the date they are received,;
- Determining if the voluntary request is valid according to the requirements in §40.1 of this guidance;
- Processing disenrollment requests in chronological order by date of receipt of completed disenrollment requests;

- Transmitting disenrollment information to CMS within *7*calendar days of the receipt of the completed disenrollment request from the individual or the employer/union *group* (whichever applies);

- For disenrollment requests received by the PDP sponsor, to notify the member in writing within *10 calendar* days after receiving the member's written request, to acknowledge receipt of the completed disenrollment request, and to provide the effective date (see **Exhibit 10**). PDP sponsors are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the reply listing.

  When the voluntary disenrollment request is denied, the PDP sponsor must send written notice within *10 calendar* days of the receipt of the request and include the reason for denial (see **Exhibit 6**).

- For all other voluntary disenrollments (i.e., voluntary disenrollments made by the beneficiary through 1-800-MEDICARE, or by enrolling in another Medicare health plan or PDP, which the PDP sponsor would not learn of until receiving the reply listing), the PDP sponsor must notify the member in writing to confirm the effective date of disenrollment within *10 calendar* days of the availability of the reply listing (see **Exhibit 11**).

40.4.2 When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete, the PDP sponsor must document all efforts to obtain additional documentation to complete the disenrollment request and have an audit trail to document why additional documentation was needed before the request could be considered complete.

If a written disenrollment request is submitted and the signature is not included, the PDP sponsor may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

Additional documentation to make the request complete must be received within 21 calendar days, or the end of the applicable enrollment period (whichever is later). If all documentation is received within allowable time frames and the request is complete, the PDP sponsor must transmit the disenrollment to CMS within the time frames prescribed in §40.4.1. If additional documentation needed to make the disenrollment request complete is not received within 21 calendar days of the PDP sponsor's request, the organization must deny the disenrollment.

40.4.*3* - Involuntary Disenrollments

The PDP sponsor is responsible for submitting involuntary disenrollment transactions to CMS in a timely, accurate fashion.

The PDP sponsor must maintain a system for controlling and processing involuntary disenrollments from the PDP sponsor. This includes:

- Maintaining documentation leading to the decision to involuntarily disenroll the member; and

- For all involuntary disenrollments except disenrollments due to death and loss of entitlement to Medicare Parts A and/or B, notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights, as provided in the applicable section of this guidance.

In addition, PDP sponsors must send confirmation of involuntary disenrollment to ensure the member discontinues use of PDP sponsor services after the disenrollment date.

40.5 - Disenrollments Not Legally Valid

When a disenrollment request that is not legally valid has been processed, a reinstatement action may be necessary (refer to §50.2 for more information on reinstatements). In addition, the reinstatement may result in a retroactive disenrollment from another plan. Since optional involuntary disenrollments (as stated in §40.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete is not legally valid. In addition, there are instances in which a disenrollment that appears to be complete can turn out to be legally invalid. For example, automatic disenrollments due to an erroneous death indicator or an erroneous loss of Medicare Part A or Part B indicator are not legally valid.

CMS also does not regard a voluntary disenrollment as actually complete if the member or his/her legal representative did not intend to disenroll from the PDP. If there is evidence that the member did not intend to disenroll from the PDP, the PDP sponsor should submit a reinstatement request to CMS (or its designee). Evidence that a member did not intend to disenroll may include:

- A disenrollment request signed by the member when a legal representative should be signing for the member; or

- Request by the member for cancellation of disenrollment before the effective date (refer to §50.1 for procedures for processing cancellations).

Discontinuation of payment of premiums does not necessarily indicate that the member has made an informed decision to disenroll.

In contrast, CMS believes that a member's deliberate attempt to disenroll from a plan (e.g., sending a written request for disenrollment to the PDP sponsor, or calling 1-800-MEDICARE) implies intent to disenroll. Therefore, unless other factors indicate that this disenrollment is not valid, what appears to be a deliberate, member-initiated disenrollment should be considered valid.

40.6 - Disenrollment Procedures for Employer /Union *Sponsored Coverage Terminations*

When an employer *or union* group terminates its contract with a PDP sponsor, or determines that a *beneficiary* is no longer eligible to participate in the employer/ union *sponsored* plan[1], the PDP sponsor has the option to follow one of two procedures to disenroll beneficiaries *from the current employer/union sponsored PDP plan in which the individual is enrolled:*

For both of these options, the PDP sponsor must ensure that the employer/union agrees to the following:

- *The employer/union will provide the PDP sponsor with timely notice of contract termination or the ineligibility of the individual to participate in the employer/union group. Such notice must be prospective, not retroactive.*

- *The employer/union must provide a prospective notice to its members alerting them of the termination event and of other insurance options that may be available to them through their employer/union.*

Option 1: *Enroll the individual(s) in another PDP (i.e. individual plan) offered by the same PDP sponsor, unless the individual(s) make other choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area.*

- *Beneficiaries may elect another PDP or MA-PD offered by the employer or union, disenroll from the PDP, or join another PDP or MA-PD plan as an individual member, if he/she chooses, instead of electing the new PDP offered by the employer/union.*

    - *If the beneficiary prefers not to be enrolled in the individual plan, he/she may contact the sponsor.*

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[1] *The employer/union establishes criteria for its retirees to participate in the employer/union sponsored PDP plan. These criteria are exclusive of the eligibility criteria for PDP enrollment. Eligibility criteria to participate and receive employer/union sponsored benefits may include spouse/family status, payment to the employer/union of the individual's part of the premium, or other criteria determined by the employer/union.*

- *If the beneficiary would prefer enrolling in a different PDP or MA-PD plan as an individual member, he/she would submit an enrollment request to his/her newly chosen PDP or MA organization.*

- *If the individual takes no other action, he/she will become a member of the individual plan offered by the same PDP sponsor that offered the employer/union sponsored plan.*

- ***PDP Notice requirements*** *-- The PDP sponsor (or the employer or union acting on its behalf) must provide prospective notice to the beneficiary that his/her plan is changing, including information about benefits, premiums, and/or copayments, at least 21 calendar days prior to the effective date of enrollment in the individual plan.*

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Option 2: *Disenroll individual(s) from the PDP sponsor following prospective notice.*

- ***PDP Notice requirements*** *- The PDP sponsor (or the employer or union, acting on its behalf) must provide prospective notice to the beneficiary that his/her plan enrollment is ending at least 21 calendar days prior to the effective date of the disenrollment. The notice must include information about other individual plan options the beneficiary may choose and how to request enrollment.*

- *If t*he employer/union *group sponsored plan was a PDP, the individual must be advised that the disenrollment action means that the individual will not have Medicare drug coverage. Notice must include information about the potential for late-enrollment penalties that may apply in the future.*

The PDP sponsor must outline in its written policies and procedures which of the above options it follows. It is the PDP sponsor's responsibility to ensure that the process it has chosen is understood by the employer/union and is part of the agreement with each employer/union, including contract termination notification requirements.

40.6.1 Group Disenrollment for Employer/Union Sponsored PDPs

CMS has provided, under our authority to waive or modify Part D requirements that hinder the design of, the offering of, or the enrollment in an employer or union sponsored Part D retiree plans, a process for group disenrollment from employer or union sponsored PDPs.

CMS will allow and employer or union *group* to disenroll its retirees from a PDP using a group disenrollment process.

The group disenrollment process must include notification to each beneficiary as follows:

- All beneficiaries must be notified that the group intends to disenroll them from the PDP that the group is offering; and
- This notice must be provided not less than 30 calendar days prior to the effective date of the beneficiary's disenrollment from the group sponsored PDP.

Additionally, the information provided must include an explanation on how to contact Medicare for information on other Part D options that might be available to the beneficiaries.

The employer or union *group* must have and provide all the information required for the PDP sponsor to submit a complete disenrollment request transaction to CMS as described in this and other CMS Part D systems guidance.

NOTE: This process applies to employer/union *group* direct contract PDP sponsors and MA Organizations and PDP sponsors that offer employer/union *group*-only plans.

50 - Post-Enrollment Activities

Post-enrollment activities occur after the PDP sponsor receives the enrollment request from the individual.

50.1 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment or disenrollment made by an individual. *Unless otherwise directed by CMS, r*equests for cancellations can only be accepted prior to the effective date of the enrollment or disenrollment request. *For employer or union groups, cancellations properly made to the employer or union prior to the effective date of the election being canceled are also acceptable.*

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary.

If a beneficiary verbally requests a cancellation of an enrollment or disenrollment request, the PDP sponsor must document the request and process the cancellation. PDP sponsors may request that the cancellation be made in writing to the PDP sponsor, however, they may not delay processing of a cancellation until the request is made in writing if they have already received verbal confirmation from the individual of the desire to cancel the enrollment or disenrollment.

50.1.1 - Cancellation of Enrollment

An individual's enrollment can only be cancelled if the request is made prior to the effective date of the enrollment*, unless otherwise directed by CMS*.

To ensure the cancellation is honored, the PDP sponsor should not transmit the enrollment to CMS. If, however, the organization had already transmitted the enrollment by the time it receives the request for cancellation, it may attempt to submit a corresponding disenrollment transaction to CMS to "cancel out" the now void enrollment transaction from the CMS enrollment system. In the event the PDP sponsor has submitted the enrollment and is unable to submit a corresponding disenrollment transaction, or has other difficulty, the PDP sponsor should contact the CMS RO in order to cancel the enrollment.

When canceling an enrollment the PDP sponsor must provide a notice to the individual that states that the cancellation is being processed. This notice should be sent within *10 calendar* days of the receipt of the cancellation request (see **Exhibit 22**).

If the member's request for cancellation occurs after the effective date of the enrollment, then the cancellation *generally* cannot be processed. The PDP sponsor must inform the member that he/she is a member of its plan. If he/she wants to get back into the other PDP he/she will have to fill out an enrollment form to enroll in that plan during an enrollment period, and with a current effective date.

50.1.2 - Cancellation of Disenrollment

A voluntary disenrollment request can only be cancelled by the individual if the request for cancellation is made prior to the effective date of the disenrollment *unless otherwise directed by CMS*.

To ensure the cancellation is honored, the PDP sponsor should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, it may attempt to submit a corresponding enrollment transaction to CMS to "cancel out" the now void disenrollment transaction. In the event the PDP sponsor has submitted the disenrollment and is unable to submit the "canceling" enrollment transaction, or has other difficulty, the PDP sponsor then the organization should contact the CMS RO in order to cancel the disenrollment.

The PDP sponsor must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using PDP services (see **Exhibit 22**). This notice should be sent within *10 calendar* days of the request.

If the member's request for cancellation occurs after the effective date of the disenrollment, then the cancellation cannot be processed. In some cases, reinstatement due to a mistaken disenrollment will be allowed, as outlined in §50.2.2. If a reinstatement

will not be allowed, the PDP sponsor should instruct the member to fill out and sign a new enrollment form to re-enroll with the PDP sponsor during an enrollment period (described in §20), and with a current effective date, using the appropriate effective date as prescribed in §20.5.

50.2 - Reinstatements

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §40.5 to determine whether a disenrollment is not legally valid). The most common reasons warranting reinstatements are:

1. Disenrollment due to erroneous death indicator,

2. Disenrollment due to erroneous loss of Medicare Part A or Part B indicator, and

3. Mistaken disenrollment. In unique circumstances, a sponsor may consult with *CMS* to reinstate members.

The RO will approve reinstatements on a case-by-case basis.

A reinstatement is viewed as a correction necessary to "erase" a disenrollment action and to ensure no gaps in coverage occur. Therefore, reinstatements may be made retroactively.

When a disenrolled member contacts the PDP sponsor to state that he/she was disenrolled due to any of the reasons listed above, and states that he/she wants to remain a member of the PDP, then the PDP sponsor must instruct the member in writing as soon as possible to continue to use PDP services (refer to **Exhibit 15**, **Exhibit 16, Exhibit 17** and **Exhibit 18** for model letters).

50.2.1 - Reinstatements for Disenrollment Due to Erroneous Death Indicator or Due to Erroneous Loss of Medicare Part A or Part B Indicator

A member can be reinstated if he/she was disenrolled due to an erroneous death or loss of Part A or Part B indicator since he/she was always entitled to remain enrolled.

To request reinstatement from the CMS (or its designee), the PDP sponsor should submit the following information to CMS (or its designee):

- A copy of the reply listing showing the disenrollment (include the system run date);

- A copy of any disenrollment letter that the PDP may have sent to the individual (see §§40.2.2 and 40.2.3). Refer to model letters in **Exhibits 10 and 11**;

- A copy of any correspondence from the member disputing the disenrollment. Member correspondence could include a summary of the dispute, phone contact reports, and copies of letters;

- A copy of the letter to the member informing him/her to continue to use *PDP coverage* until the issue is resolved. Refer to model letters in **Exhibits 15 and 16**; and

- Verification that the disenrollment was erroneous. This verification can be shown via documentation from SSA stating its records have been corrected or that its records never showed the member as being deceased or having lost entitlement. It may also be shown by a CMS or CMS subcontractor print screen supporting the uninterrupted existence of Medicare Part A or B entitlement.

50.2.2 - Reinstatements Due to Mistaken Disenrollment Made By Member

Reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who are able to cancel the disenrollment before the effective date of the disenrollment (as outlined in §40.2.2), given that this type of cancellation generally results in no changes to CMS records.

Reinstatements will be allowed at the request of a member who enrolled in *another* PDP, which resulted in an erroneous disenrollment from the original PDP in which he/she was enrolled, and who was able to cancel the enrollment in the *another* PDP (as outlined in §40.2.1). When a cancellation of enrollment in a*nother* PDP is properly made, the associated automatic disenrollment from the first PDP becomes invalid. Generally, these reinstatements will only be granted when the member submits the request for reinstatement in writing in the time frames described in the next paragraph, and has only used pharmacy services from providers in the original (first) PDP since the original effective date of the disenrollment.

In these cases, when a disenrolled member verbally contacts the original PDP sponsor to state that he/she mistakenly disenrolled, and states that he/she wants to remain a member of the plan, the PDP sponsor must instruct the member to notify the PDP sponsor in writing of the desire to remain enrolled in the plan within 30 calendar days after the PDP sponsor sent the notice of disenrollment to the individual (i.e., the notice shown in **Exhibit 10**). Regardless of whether the request for reinstatement is verbal or in writing, the PDP sponsor must also instruct the member as soon as possible to continue to use PDP plan services (see **Exhibit 1*7***).

If the PDP sponsor does not receive the written statement requested from the member within the required time frame, then it must close out the reinstatement request by notifying the individual of the denial of reinstatement (see **Exhibit 1*8***), and should do so within *10 calendar* days after the date the member's written request was due at the PDP sponsor.

To request reinstatement from CMS the PDP sponsor must submit the following information to CMS (or its designee):

- A copy of the reply listing showing the disenrollment (include the system run date);
- A copy of the disenrollment letter sent to the individual. Refer to model letter in **Exhibit 10** (or **Exhibit 11**, if appropriate);
- A copy of any correspondence from the member disputing the disenrollment and indicating that he/she wants to remain enrolled in the plan. Member correspondence could include a summary of the facts, phone contact reports, and copies of letters;
- A copy of the letter to the member informing him/her to continue to use PDP plan services until the issue is resolved and instructing him/her to state the intent to continue enrollment in writing. Refer to model letter in **Exhibit 17**; and
- A copy of the written statement from the member indicating he/she wants to remain enrolled in the PDP.

50.3 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the PDP sponsor or CMS is unable to process the enrollment for the required effective date (as outlined in §20.4), CMS (or its designee) will process a retroactive enrollment.

In addition, auto-enrollment for full-benefit dual eligible as described in §30.1.4 may be retroactive to ensure no coverage gap between the end of Medicaid coverage for Part D drugs and the beginning of Medicare drug coverage.

In other limited cases, CMS may determine that an individual is eligible for an SEP due to an extraordinary circumstance beyond his/her control (e.g. a fraudulent enrollment request or misleading marketing practices) and may also permit a retroactive enrollment in an PDP as necessary to prevent a gap in coverage or liability for the late enrollment penalty.

Unlike a reinstatement, which is a correction of records to "erase" an action, a retroactive enrollment is viewed as an action to enroll a beneficiary into a plan for a new time period.

*When an individual has fulfilled all enrollment requirements, but the organization or CMS is unable to process the enrollment, t*he following documentation must be submitted to CMS (or its designee). The retroactive enrollment request should be made within 45 calendar days of the availability of the first *transactions* reply *report*.

1. A copy of signed completed enrollment form.

   NOTE: The form must have been signed by the applicant prior to the requested effective date of coverage, in order to effectuate the requested effective date of coverage.

   Or

   A copy of the enrollment request record (the record must show that the election was made prior to the requested effective date of coverage).

2. A copy of PDP sponsor's letter to the member acknowledging receipt of the completed enrollment request. The letter must be dated prior to the requested retroactive effective date of coverage (or, when appropriate as outlined in §30.4.2, within *10 calendar* days after the effective date of coverage), in order to effectuate the requested effective date of coverage.

3. Copies of *at least one transaction* reply *report*, indicating the PDP sponsor's attempts to *submit valid enrollment transactions that were rejected*. The effective date on the reply listing must correspond with the requested effective date, in order to effectuate the retroactive effective date of coverage.

50.4 - Retroactive Disenrollments

*I*f an enrollment was never legally valid (§30.5) or if a valid request for disenrollment was properly made, but not processed or acted upon (as outlined in the following paragraph), which includes not only system error, but plan error), CMS (or its designee) may also grant a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the plan service area (as outlined in §40.2.1), a contract violation*, or other limited exceptional conditions established by CMS (e.g. fraudulent enrollment or misleading marketing practices)*.

Retroactive disenrollments can be submitted to CMS (or its designee) by the beneficiary or a PDP sponsor. Requests from a PDP sponsor must include supporting evidence *(e.g. a copy of the disenrollment request) and an explanation as to why the disenrollment was not processed correctly.* PDP sponsors must submit retroactive disenrollment requests to CMS (or its designee) as soon as possible. If CMS (or its designee) approves a request for retroactive disenrollment, the PDP sponsor must return any premium paid by the member for any month for which CMS processed a retroactive disenrollment. In addition, CMS will retrieve any capitation payment for the retroactive period.

A retroactive request must be submitted by the PDP sponsor (or by the member) in cases where the PDP sponsor has not properly processed or acted upon the member's request for disenrollment as required in §40.4.1 of these instructions. A disenrollment request would be considered not properly acted upon or processed if the effective date is a date other than as required in §20.5.

50.5 - Retroactive Transactions for *Employer/Union Group Health Plan (*EGHP*)* Members

In some cases, there can be a delay between the time the member makes a valid disenrollment request through the EGHP, and when that request is received by the PDP sponsor. Therefore, retroactive transactions for these routine delays may be necessary and are provided for under this section. Errors made by an EGHP, such as failing to forward a valid enrollment or disenrollment election within the timeframes described below, must be submitted to the CMS (or its designee) for review. Repeated errors may indicate an ongoing problem and therefore will be forwarded to the PDP sponsor's CMS Plan Manager for compliance monitoring purposes. The PDP sponsor's agreement with the EGHP *must* include the need to meet the requirements provided in this chapter that ensure the timely submission of enrollment and disenrollment requests to reduce the need for retroactivity and to help avoid errors.

50.5.1 - EGHP Retroactive Enrollments

*T*he effective date *of EGHP enrollments* cannot be prior to the date the enrollment request was completed by the individual. The effective date may be *retroactive up to*, but not exceeding, 90 days *from the date the PDP received the request (which was completed prior to the effective date) from the employer or union group*.

EXAMPLE

In March 2007, the CMS system processing date was March 13, 2007. Enrollments processed by CMS for the March 13, 2007 due date were for the prospective April 1, 2007, payment. For EGHPs, an effective date of March 1, February 1, or January 1 would reflect 30-, 60-, and 90-days of retroactive payment adjustment, respectively. Therefore, if a completed EGHP enrollment were to be received on March 5, 2007, the retroactive effective date could be January 1, February 1, or March 1*, as long as the enrollment request was completed prior to the effective date*.

No retroactive enrollments may be made unless there has been a valid enrollment request and the PDP sponsor (or EGHP) provided him/her with the explanation of enrollee rights at the time of enrollment. The PDP sponsor should submit such enrollments using *Transaction Code* 60. Please *refer to Chapter 19, "Managed Care and MA Systems Requirements" and the Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) for more information. Transaction Code 60 is to be used only for the purpose of submitting a retroactive enrollment into an EGHP made necessary due to the employer's delay in forwarding the completed enrollment request to the Part D organization.*

50.5.2 - EGHP Retroactive Disenrollments

The PDP sponsor must submit a retroactive disenrollment request to CMS (or its designee) if an *EGHP* does not provide the PDP sponsor with timely notification of a member's requested disenrollment. Up to a 90-day retroactive disenrollment is possible. The *EGHP* notification is considered untimely if it does not result in a disenrollment effective date as outlined in §20.5.

The PDP sponsor must submit a disenrollment notice (i.e., documentation) to CMS (or its designee) demonstrating that the disenrollment request was made in a timely fashion (i.e., prospectively), but that the *EGHP* was late in providing the information to the PDP sponsor. Such documentation may include an enrollment request made by the member for a different plan and given to the *EGHP* during the *EGHP*'s open enrollment season. Such documentation should be sent to CMS (or its designee) as soon as possible.

50.6 – Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment (or disenrollment) request for the same individual with the same effective date in the same reporting period. An individual may not be enrolled in more than PDP at any given time (however, an individual may be simultaneously enrolled in a cost plan and a separate PDP plan or in certain MA plan types and a separate PDP plan).

If multiple transactions are submitted during the period, generally, the last enrollment request the beneficiary makes during an enrollment period will be accepted as the PDP into which the individual intends to enroll. If an individual requests enrollment in more than one PDP for the same effective date and with the same application date, the first transaction successfully processed by CMS will take effect. Because simultaneous enrollment in a PDP and certain MA plan types is permitted, CMS systems will accept such enrollments.

Generally, given the use of the application date to determine the intended enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because enrollment requests have the same application date.

EXAMPLES

- *Two PDP sponsors receive enrollment requests from one individual. PDP #1 receives a form on December 4th and PDP #2 receives a form on December 10. Both organizations submit enrollment transactions, including the applicable effective date and application date. The enrollment in PDP #2 will be the transaction that is accepted and will be effective on January 1 because the application date on the enrollment transaction is the later of the two transactions submitted. Both plans receive the appropriate reply on the transaction reply report.*

- *Two PDP sponsors receive enrollment requests from one individual for a January 1 effective date. PDP #1 receives a paper enrollment form with all required information on December 5th. The beneficiary completed an enrollment request for PDP #2 by telephone on the same day, December 5th. Both enrollment requests have the same application date, since they were received by the PDP sponsors on the same date. Both enrollments were submitted to CMS prior to the December cut-off date. PDP #1 transmitted the enrollment to CMS on December 5th, the day it received the enrollment request; however, PDP #2 waited December 8th to transmit the enrollment to CMS. The enrollment for PDP #1 will be the transaction that is effective on January 1, as it was the first transaction successfully processed by CMS.*

In the event a rejection for a multiple transaction is reported to the PDP sponsor, the sponsor may contact the individual. If the individual wishes to enroll in a PDP offered by the sponsor that received the multiple transactions reject, s/he must submit a new enrollment request during a valid enrollment period.

50.7 – User Interface (UI) Transactions Reply Codes (TRC) – Communications with Beneficiaries

Upon receipt of a CMS transaction reply, PDP sponsors must update their records to accurately reflect each individual's enrollment status. Sponsors are also required to provide certain notices and information to beneficiaries when enrollment status is confirmed or changes. In the case of UI-TRC replies, the standard operating procedures for providing these notices and/or information may not fit some of the unique situations many UI enrollment changes address.

The table below provides guidelines for communicating with beneficiaries when enrollment changes are reported to PDP sponsors using the "700 series" TRCs that result from UI enrollment changes. In all cases, PDP sponsors will need to review the situations carefully to determine the necessity and appropriateness of sending notices. Some UI enrollment change processes will result in multiple 700-series TRCs being reported. PDP sponsors must determine the final disposition of the beneficiary to ensure the correct message is provided in any notice sent. CMS encourages plans to communicate directly (such as by telephone) with the beneficiary, in addition to any required notice or materials. When it is necessary to send a notice, organizations must issue the notice within ten calendar days of receipt of the transaction reply report.

TRC	***Beneficiary Communication Action***
701 – New UI Enrollment	*Plans may use existing confirmation notices as provided in CMS enrollment guidance. If such notice has already been provided with the same information, it is not necessary to provide it a second time.*
702 – New UI Fill-in	*Plans must use **Exhibit 31,** "Enrollment Status Update".*

Enrollment	*Include the date range covered by the new fill-in period.*
703 – UI Enrollment Cancel	*If a cancellation notice applicable to this time period has already been provided, it is not necessary to provide it a second time. If notice has not been provided, plans may use the existing cancellation of enrollment notice as provided in CMS enrollment guidance. If the specific situation warrants, plans may use **Exhibit 31** instead, providing information that clearly indicates that the enrollment period in question has been cancelled. Include information about the refunding of plan premiums, if applicable.*
704 – New UI Enrollment – PBP Change	*If the UI action is a correction to a plan submission error, you may have already provided the correct plan (PBP) information; if that's the case, it is not necessary to send it a second time. If the beneficiary has not received information about the specific plan (PBP), you must send the materials required in CMS enrollment guidance that you would provide for any new enrollment. You must also send **Exhibit 31** describing the plan change including the effective date. Ensure that you communicate clearly the impact of the change on plan premiums, cost sharing, and provider networks. It is not necessary to confirm with a notice the associated "enrollment canceled" TRC that will accompany the enrollment into the new plan (PBP).*
705 – UI Enrollment Cancel – PBP change	*Follow the guidance provided above for TRC 704.*
706 – UI New Enrollment – Segment Change	*Plan (PBP) segment changes only apply to MA plans. Provide updated materials reflecting the new elements of the changed segment, such as premium and cost sharing increases or decreases.*
707- UI Enrollment Cancel – Segment Change	*Follow the guidance above for TRC 706.*
708 – UI End Date Assigned	*This UI action has the same effect as a plan submitted disenrollment (code 51) transaction. Generally, plans should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated changes are retroactive, plans may have already provided notice (with correct effective dates) and if so, need not provide it a second time. Additional clarification may be appropriate depending on the specifics of the case.*
709 – UI Earlier Start Date	*An existing enrollment period in the plan has changed to start earlier than previously recorded. If the plan has already provided notice reflecting this effective date of enrollment, it is not necessary to provide it a second time. When the individual has not already received notice reflecting this effective date, plans may use existing confirmation of*

	*enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, plans may use **Exhibit 31**, including in it the new effective date and information about additional premium liability (ensure flexibility in allowing payment arrangements where necessary). Plans must also ensure individuals are fully aware of how to access coverage of services for the new time period, including their right to appeal.*
710 – UI Later Start Date	*An existing enrollment period start date has been changed to start on a later date. Plans must use **Exhibit 31**. Plans must explain the change in the effective date of coverage, and provide information on the refunding of any premiums paid. Plans must also explain the impact on any paid claims from the time period affected.*
711 – UI Earlier End Date	*An enrollment period end date has been changed to occur earlier. Plans must use **Exhibit 31**. Plans must explain the change in the effective date of the end coverage, and provide information on the refunding of any premiums paid. Plans must also explain the impact on any paid claims from the time period affected*
712 – UI Later End Date	*An enrollment period end date has been changed to occur later. Plans must use **Exhibit 31**. Plans must explain the change in the effective date of the end of coverage, and provide information on any premiums the individual may owe for the extended period. Plans must also ensure beneficiaries are fully aware of how to access coverage of services for the new time period.*
713 – UI Removed End Date	*An enrollment period that previously had an end date is now open (and ongoing). Plans must use **Exhibit 31** to explain the change and that enrollment in the plan is now continuous. Plans must provide information on any plan premiums and ensure beneficiaries are fully aware of how to access coverage of services for the new time period and going forward.*

50.*8* - Storage of Enrollment and Disenrollment Request Records

PDP sponsors are required to retain records of enrollment and disenrollment requests (i.e. copies of enrollment forms, etc.) for the current contract period and 10 (ten) prior periods, as stated at 42 CFR §423.505(e)(1)(iii).

APPENDICES

Summary of PDP Notice and Data Element Requirements

Appendix 1: Summary of Notice Requirements

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

Note on transaction reply reports (TRR): For enrollments, PDP sponsors will have the option as described in Section 30; disenrollment notices must be based upon the monthly transaction reply report (TRR).

Notice	Section	Required?	Timeframe
Medicare Prescription Drug Plan Individual Enrollment Form (Exh. 1)	30.1.1	Yes[2]	NA
Optional information to include on or with Enrollment Form -- Information to Determine Enrollment Periods (Exh. 1a)	20	No	NA
Acknowledge Receipt of Enrollment *Request* (Exh. 2)	30.4.1	Yes[3]	*10 calendar* days of receipt of enrollment *request*
Acknowledge Receipt of Enrollment *Request* – Enrollment in another Plan Within the Same PDP Organization (Exh. 2a)	30.4.1	Yes	*10 calendar* days of receipt of completed enrollment election
Acknowledge Receipt of Enrollment and Confirmation of Enrollment (Exh. 2b)	30 and 30.4	Yes[4]	*7 calendar days of receipt of reply listing*
Request for Information (Exh. 3)	30.2.2	No	NA
Confirmation of Enrollment (Exh. 4)	30.4.2	Yes[5]	*10 calendar* days of monthly reply listing
Individuals Identified on CMS Records As Members of Employer/Union Receiving Employer Subsidy (Exh. 5)	10.4	Yes	*10 calendar* days of monthly reply listing
PDP Organization Denial of Enrollment (Exh. 6)	30.2.3	Yes	*10 calendar* days of denial determination

[2] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[3] Unless combine acknowledgment & confirmation notice, per section 30.4
[4] Required if the PDP sponsor has chosen to provide a single notice in response to the weekly TRR, as described in section 30 and 30.4
[5] Required unless combined acknowledgment/confirmation notice is issued

Notice	Section	Required?	Timeframe
CMS Rejection of Enrollment (Exh. 7)	30.4.3	Yes	*10 calendar* days of reply listing
Send Out Disenrollment Form/ Disenrollment Form (Exh. 8 – 9)	40.1	No	NA
Acknowledgement of Receipt of Voluntary Disenrollment Request from Member (Exh. 10)	40.1.5	Yes	*10 calendar* days of receipt of request to disenroll
Final Confirmation of Voluntary Disenrollment Identified Through Reply Listing (no exhibit)	40.1.5	Yes	*10 calendar* days of reply listing
PDP Denial of Disenrollment (Exh. 11)	40.1.5	Yes	*10 calendar* days of denial determination
CMS Rejection of Disenrollment (Exh. 12)	40.1.5	Yes	*10 calendar* of reply listing
Disenrollment Due to Permanent Move (no exhibit)	40.2.1		Within *10 calendar* days of learning of the permanent move and no later than before the disenrollment transaction is submitted to CMS
Disenrollment Due to Death (Exh. 13)	40.2.3	Yes	*10 calendar* days of reply listing
PDP Model Notice for auto-enrollments provided by CMS with recent deceased code (Exh. 13a)	30.1.4. D	Yes	*10 calendar* days of reply listing
Disenrollment Due to Loss of Medicare Part A and/or Part B (Exh. 14)	40.2.2	Yes	*10 calendar* days of reply listing
Notices on Terminations/Nonrenewals	note[6]	Yes	Follow requirements in 42 CFR 423.506 - 423.512
Advanced Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	40.3.2	Yes	
Intent to request CMS' permission to disenroll the member	40.3.2	Yes	
Confirmation of Disenrollment for Disruptive Behavior (no exhibit)	40.3.2	Yes	Before disenrollment transaction submitted to CMS
Disenrollment for Fraud & Abuse (no exhibit)	40.3.3	Yes	Before disenrollment transaction submitted to CMS
Offering Beneficiary Services,	50.2.1	Yes	*10 calendar* days of initial

[6] Provided under separate CMS guidance

Notice	Section	Required?	Timeframe
Pending Correction of Erroneous Death Status (Exh. 15)			contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination (Exh. 16)	50.2.1	Yes	*10 calendar* days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another PDP Organization (Exh. 17)	50.2.2	Yes	*10 calendar* days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	50.2	Yes	*10 calendar* days after information was due to organization
Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage (Exh. 19)	40.3.1	Yes	Within *10 calendar* days after the 1st of the month for which delinquent premiums due
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	40.3.1	Yes	Before disenrollment transaction submitted to CMS
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	40.3.1	Yes	*10 calendar* days of reply listing
Acknowledgement of Request to Cancel Enrollment (Exh. 22)	40.3.1	Yes	*10 calendar* days of request
Acknowledgement of Request to Cancel Disenrollment (Exh. 23)	50.1.1	Yes	*10 calendar* days of request
Inform member of Auto-enrollment (Exh. 24)	30.1.4. D	Yes	*10 calendar* days of reply listing or address report, whichever is later
Inform member of Facilitated Enrollment (Exh. 25)	30.1.*4*. D	Yes	*10 calendar* days of reply listing or address report, whichever is later
Request to Decline Part D (Exh. 26)	30.1.4.E & 30.1.*4*.E	Yes	*10 calendar* days of request
Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region (Exh. 27)	40.2.1	No	*10 calendar* days of reply listing

Notice	Section	Required?	Timeframe
Auto and Facilitated Enrollees Who Permanently Reside in another Region Where PDP Sponsor Does Not offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region (Exh. 28)	40.2.1	Yes	*10 calendar* days of reply listing
Reassignment Confirmation (Exh. 29)	*30.1.5E*	*Yes*	
Optional Notice for "Losing Plan" to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC) (Exh. 30)	*30.1.5E*	*No*	
Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes (Exh. 31)	*50.7*	*As necessary*	*10 calendar days of receipt of reply listing*

Appendix 2: Data Elements Required to Complete the Enrollment

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

	Data Element	Required before enrollment complete?
1	PDP Plan name	Yes
2	PDP plan/product	Yes
3	Beneficiary name	Yes
4	Beneficiary Birth Date	Yes
5	Beneficiary Sex	Yes
6	Social Security Number	No
7	Beneficiary Telephone Number	No
8	Permanent Residence Address	Yes
9	Mailing Address	No
10	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	No
11	E-mail address	No
12	Beneficiary Medicare number	Yes
13	Additional Medicare information contained on sample Medicare card, or copy of card	No[7]
14	Plan Premium Payment Option	No[8]
15	Response to other insurance COB information	No[9]
16	Response to long term care question	No
17	Beneficiary signature and/or Beneficiary Representative Signature	Yes[10]
18	Date of signature	No[11]
19	Authorized Representative contact information (if not signed by beneficiary)	Yes

[7]. We recognize that the PDP needs, at a minimum, the Medicare number in order to verify entitlement to Part A and/or enrollment in Part B; we have accounted for the need for this data element under data element number 4.

[8] Response defaults to *direct bill* if applicant fails to provide information

[9] Refer to CMS COB guidance for additional information

[10] Applicable only to requests made using a paper enrollment form. If signature is missing, plan may follow up and document, as described in Section 30.2. F

[11] As explained in §30.2, the beneficiary and/or legal representative should provide the date s/he completed the enrollment form; however, if s/he inadvertently fails to include the date on the enrollment request, then the date of receipt that the PDP assigns to the enrollment request may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

EXHIBITS:

PDP Model Enrollment Form & Notices

Exhibit 1 - PDP Model Enrollment Form

[Logo/Name of the Medicare Drug Plan]

<PDP NAME> **MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM**

To enroll in <PDP name>, Please Provide The following Information:			
[Optional Field] **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	*[optional field]* Social Security Number: *(providing this information is optional)*	Home Phone Number: ( )
Permanent Residence Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
Emergency contact: [Optional field] _____ **Phone Number**: [Optional field]_____**Relationship to You** [Optional field]_____			
[optional field] **E-mail Address:**			

Please Provide Your Medicare Insurance Information	
Please take out your Medicare Card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card - OR - • Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.	 SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

Paying Your Plan Premium

You can pay your monthly plan premium 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 Check each month.***

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 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: "coupon", "payment" book, etc>*
<option to include other billing intervals e.g. bi-monthly, quarterly>

<Include other optional 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 SSA benefit check. (The SSA deduction may take two or more months to begin. In most cases, the first deduction from your SSA benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)*

Please Answer the Following Questions:

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 <PDP name>? ☐ 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. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes" please provide the following information:

Name of Institution: _____

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

Please Read This Important Information

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining <PDP name>, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

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

Please Read and Sign Below:

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

<PDP Name> is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform <PDP name> of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time *– if I am currently in a Medicare prescription drug plan, my enrollment in <PDP name> will end that enrollment* Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <PDP Name> or *by calling 1-800-Medicare, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.*

<PDP Name> serves a specific service area. If I move out of the area that <PDP 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 <PDP Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from <PDP name> when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that <PDP Name> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. *I also acknowledge that <PDP Name> will release my information, including my prescription drug event date, 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 behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the

contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <PDP Name> or by Medicare.

Your Signature:	**Today's Date:**

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

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

Medicare Prescription Drug Plan Use Only:

Plan ID #:_____
Effective Date of Coverage: _____ IEP: _____ AEP: _____ SEP (type): _____
Plan Representative Signature:_____

[*optional space for other administrative information needed by plan*]

Exhibit 1a – Optional information to include on or with Enrollment Form -- Information to Determine Enrollment Periods

Referenced in section: 20

Typically, you may only enroll in a Medicare Prescription Drug Plans during the annual open enrollment period between November 15 and December 31 of each year. However, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual open enrollment period.

Please read the following statements and please check the box to the left of the statement(s) and your selected plan will contact you for additional information.

- ☐ I am new to Medicare.
- ☐ I recently moved outside of my current Medicare health plan's or Medicare prescription drug plan's service area.
- ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ☐ I *receive* extra help paying for Medicare prescription drug coverage.
- ☐ *I am no longer eligible for extra help paying for my Medicare prescription drugs.*
- ☐ I *live in* a Long Term Care Facility (for example, a nursing home or long term care *facility*).
- ☐ *I just moved out of a Long Term Care Facility (for example, a nursing home or long term care facility).*
- ☐ I recently left a PACE program.
- ☐ I recently involuntarily lost my coverage that is *creditable prescription drug coverage (*as good as Medicare's*)*").
- ☐ I am either losing coverage I had from an employer or leaving employer coverage.
- ☐ *I belong to a pharmacy assistance program provided by my state.*
- ☐ *I recently returned to the United States after living permanently outside of the U.S.*

If none of these statements apply to you or if you are not sure, please contact us to see if you are eligible to enroll.

Exhibit 2 - PDP Model Notice to Acknowledge Receipt of Completed Enrollment

Referenced in section: 30.4.1

<**Member # - if** *member # is SSN, only use last 4 digits*
<**RxID**>
<**RxGroup**>
<**RxBin**>
<**RxPCN**>

<Date>
Dear <Name of Member>:

Thank you for enrolling in <PDP name>. <PDP name> is a Prescription Drug Plan that is approved by Medicare. Your enrollment will be effective on <effective date>.

As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <PDP name> may not pay for your prescriptions. [***Optional language*:** This letter is proof of your <PDP name> coverage. You should show this letter at the pharmacy until you get your Member ID card from us.]

Medicare must approve all enrollments and calculate your premium amount. When Medicare approves your enrollment into <PDP name>, we will send you a letter to confirm your enrollment in <PDP name>. You will get a separate letter from <PDP name> once Medicare calculates your premium. You should not wait to get these confirmation letters before you begin using <PDP name> network pharmacies on <effective date>. If Medicare rejects your enrollment, <PDP name> will bill you for any prescriptions you received through us.

If you have health coverage from an employer or union, or other entity, joining <PDP Name> may change how your current coverage works. Read the communications your employer, union, or other source of coverage 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. If you have other prescription drug coverage, such as through an employer plan, you shouldn't cancel your other coverage yet. Keep your other coverage until you receive the confirmation letter from us.

If you have a Medigap (Medicare Supplement Insurance) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

Once you are enrolled in our plan, you can only disenroll (or enroll in a new plan) during certain times of the year. Unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area *or if you qualify for extra help*, you can only disenroll from <PDP name> from November 15 through December 31 each year. If you have questions about how or when to disenroll from <PDP name>, please call our customer service department.

If you chose to have your <PDP name> premium withheld from your Social Security, remember that your benefit check will reflect this deduction. If you did not choose this option, we will bill you for your monthly premiums. Generally you must stay with the premium payment option you choose for the rest of the year. [PDPs that disenroll for nonpayment of premium include the following sentence: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

People with limited incomes may qualify for extra help to pay for their drugs costs (including help paying the <PDP name> premium and yearly deductible). For more information about this extra help, contact your local Social Security office or *call 1-800-Medicare, 24 hours per day, 7 days per week.*. TTY/TDD users should call 1-877-486-2048.

Please remember that you should use <PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 2a - Model Notice to Acknowledge Receipt of Completed Enrollment in another Plan in the Same Part D Organization

Referenced in section: 30.4.1

<**Member # -** *if member # is SSN, only use last 4 digits*>
<**RxID**>
<**RxGroup**>
<**RxBin**>
<**RxPCN**>

<Date>
Dear < Member>:

Thank you for the request to change your enrollment from <former PDP name> to <new PDP name>. <New PDP name> is a Prescription Drug Plan that is approved by Medicare. Your enrollment will be effective on <effective date>.

As of <effective date>, you should begin using <new PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <new PDP name> may not pay for your prescriptions. *[Optional language***:** This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us**.***]*

Medicare must approve all enrollments and calculate your premium amount. When Medicare approves your enrollment, we will send you a letter to confirm your enrollment with <new PDP name>. You will get a separate letter from <PDP name> once Medicare calculates your premium. But, you should not wait to get these confirmation letters before you begin using <new PDP name> network pharmacies on <effective date>.

Once you are enrolled in our plan, you can only disenroll (or enroll in a new plan) during certain times of the year. Unless you meet certain special exceptions, such as if you move out of <new PDP name>'s service area, you can only disenroll from <new PDP name> from November 15 through December 31 of each year. If you have questions about how or when to disenroll from <new PDP name>, please call our customer service department.

If you chose to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. If you did not choose this option, we will bill you for your monthly premium. Generally you must stay with the premium payment option you choose for the rest of the year. [*PDPs that disenroll for nonpayment of premium include the following sentence*: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

Please remember that you should use <new PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <new PDP name> may not pay for your prescriptions. You can find network

pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 2b - PDP Model Notice to Acknowledge Receipt of Completed Enrollment and to Confirm Enrollment

Referenced in section: 30.4.1

<**Member # -** *if member # is SSN, only use last 4 digits*>
<**RxID**>
<**RxGroup**>
<**RxBin]**>
<**RxPCN**>

<Date>
Dear <Name of Member>:

Thank you for enrolling in <PDP name>. <PDP name> is a Prescription Drug Plan that is approved by Medicare. Medicare has approved your enrollment in <PDP name> beginning <effective date>. As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <PDP name> may not pay for your prescriptions.

*[Optional language***:** This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us**.]**

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

[Insert the following if LEP applies: You are being charged an additional <LEP amount> each month because our records show that you didn't have creditable prescription drug coverage (as good as Medicare's) for <# of uncovered months> months.

[Insert the following ONLY if EGWP plan sponsor is paying the LEP amount on behalf of the individual: <Name of employer or union sponsoring the Plan> has agreed to pay <LEP amount>, the amount of your late enrollment penalty, on your behalf. If your coverage is terminated by you or <name of employer or union sponsoring the Plan>, or if <name of employer or union sponsoring the Plan> stops paying your late enrollment penalty, you will be responsible for paying that amount.

[Insert if LEP applies: ***If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision.*** *(For example, you might disagree with the penalty if you were affected by Hurricane Katrina or if you got/get extra help from Medicare to pay for your prescription drug coverage in 2006 and/or 2007.) A notice explaining your right to a reconsideration of the late enrollment penalty is included with this letter.* ***You must submit your reconsideration request within 60 days of the date of this letter, or Medicare may not consider your request.***

If you have questions about the information in this letter, or if you would like more information about the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.]

[Insert if low-income subsidy applicable:

Because you qualify for extra help with your prescription drug costs, you will pay:

- <plan premium less premium assistance for which individual is eligible> per month for your <PDP name> premium,
- <insert $0 or $50> for your yearly prescription drug plan deductible,
- <insert copay amount $0, up to $1*.05* and $3*.10*, up to $2*.25* and $5*.60* copayments, or 15% coinsurance]> when you fill a prescription.*]*

[*PDP plans without a premium – do not use the following paragraph:* If you have chosen to have your monthly premium for this plan withheld from your Social Security payment, remember that your benefit check will reflect this deduction. If you did not choose this option, we will bill you for your monthly premium. Generally you must stay with the premium payment option you choose for the rest of the year. [PDPs that disenroll for nonpayment of premium include the following sentence: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 3 - Model Notice to Request Information

Referenced in section: 30.2.2

<Date>

Dear <Name of Member>:

Thank you for applying with <PDP name>. We cannot process your enrollment until we get the following information from you:

_____ Proof that you have Medicare Part A and/or Part B. *Please* send us a copy of your Medicare card as proof of your Medicare coverage.

_____ Other: _____

You will need to provide this information to <plan name> by <date>. You can contact us by phone with this information by calling <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. Or, you may also fax it to us at <fax number> or send it to us at <address>. If you cannot send this information by <date>, we will have to deny your request to enroll in our Plan.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 4 - PDP Model Notice to Confirm Enrollment

Referenced in section: 30.4.2

<**Member # -** *if member # is SSN, only use last 4 digits*>
<**RxID**>
<**RxGroup**>
<**RxBin**>
<**RxPCN**>

<Date>

Dear <Name of Member>:

Medicare has approved your enrollment in <PDP name> beginning <effective date>.

As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <PDP name> may not pay for your prescriptions.

*[Optional language***:** This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us.*]*

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

[Insert the following if LEP applies:

You are being charged an additional <LEP amount> each month because our records show that you didn't have creditable prescription drug coverage (as good as Medicare's) for <# of uncovered months> months.]

[Insert the following ONLY if EGWP plan sponsor is paying the LEP amount on behalf of the individual: <Name of employer or union sponsoring the Plan> has agreed to pay <LEP amount>, the amount of your late enrollment penalty, on your behalf. If your coverage is terminated by you or <name of employer or union sponsoring the Plan>, or if <name of employer or union sponsoring the Plan> stops paying your late enrollment penalty, you will be responsible for paying that amount.]

*[Insert if LEP applies**: If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision.** (For example, you might disagree with the penalty if you were affected by Hurricane Katrina or if you got/get extra help from Medicare to pay for your prescription drug coverage in 2006 and/or 2007.) A notice explaining your right to a reconsideration of the late enrollment penalty is included with this letter. **You must submit your**

reconsideration request within 60 days of the date of this letter, or Medicare may not consider your request.

If you have questions about the information in this letter, or if you would like more information about the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.]

[Insert if low-income subsidy applicable:

Because you qualify for extra help with your prescription drug costs, you will pay:

- <plan premium less premium assistance for which individual is eligible> per month for your <PDP name> premium,
- <insert $0 or $50> for your yearly prescription drug plan deductible,
- <insert copay amount $0, up to $1*.05* and $3*.10*, up to $2*.25* and $5*.60* copayments, or 15% coinsurance> when you fill a prescription.*]*

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare prescription drug plan. Your Medigap Issuer will remove the prescription drug coverage portion of your policy and adjust your premium. Call your Medigap Issuer for details.

[Insert if LEP applies: **If you believe your late enrollment penalty is incorrect**, call <plan name> at <plan telephone number> to find out how you can ask for a reconsideration (review) of the late enrollment penalty. Your reconsideration request must be filed by <date of this letter + 60 days>. **Keep a copy of this letter.** If you ask for a reconsideration of the late enrollment penalty decision, you will need to include a copy of this letter with your request.*]*

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 5 - PDP Model Notice to Individuals Identified on CMS Records As Members of Employer/Union *Group* Receiving Employer Subsidy

Referenced in section: 10.4

<Date>

Dear < Member>:

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

Medicare has informed us that you belong to an employer *or union group* health plan that includes prescription drug coverage.

It is important that you consider your decision to enroll in our Plan carefully. If you have health coverage from an employer or union, joining <PDP Name> may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help

If you have already discussed this decision with your employer or union contact and have decided that you would like to be a member of <PDP name>, **please confirm this by calling <PDP name> customer service at the number below.** Your enrollment will not be complete until you call and confirm this information. Your enrollment will be effective <effective date>.

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

To confirm your enrollment, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Exhibit 6 - PDP Model Notice for Denial of Enrollment

Referenced in section: 30.2.3

<Date>

Dear <Name of Beneficiary>:

Thank you for applying with <PDP name>. We cannot accept your request for enrollment in <PDP name> because of the reason(s) checked below.

1. _____ You have neither Medicare Part A nor Part B.
2. _____ Your permanent residence is outside of our service area.
3. _____ You attempted to enroll outside of an enrollment period.
4. _____ We did not receive the information we requested from you within the timeframe listed in our request.

If <PDP name> paid for any of your prescriptions, we will bill you for the amount we paid.

If item 3 is checked, remember that you can enroll in and disenroll from a Medicare prescription drug plan only at certain times during the year. *If* you meet certain special exceptions, such as if you move out of <PDP name>'s service area *or if you receive extra help*, *you may enroll in a new plan at any time. Otherwise,* you can *only* enroll in a plan, disenroll from a plan, or switch plans between November 15th and December 31st of each year.

If any of the checked items are wrong, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 7 - PDP Model Notice for CMS Rejection of Enrollment

Referenced in section: 30.4.2

<Date>

Dear <Name of Beneficiary>:

Medicare has denied your enrollment in <PDP name> due to the reason(s) checked below.

1. _____ You have neither Medicare Part A nor Part B.

2. _____ You requested to enroll in a different Plan for the same effective date, which canceled your enrollment with <PDP name>.

3. _____ You attempted to enroll outside of an enrollment period.

If <PDP name> paid for any of your prescriptions, we will bill you for the amount we paid.

If any of the checked items are wrong, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 8 - PDP Model Notice to Send Out Disenrollment Form

Referenced in section: 40.1

<Date>

Dear < Member>:

Attached is the <PDP name> disenrollment form you requested. If you would like to disenroll from <PDP name>, please fill out the form, sign it, and send it back to us in the enclosed envelope. You can also fax a signed and dated form to us at <fax number>.

Medicare will only allow you to disenroll at certain times during the year. After we receive your disenrollment form, <PDP name> will let you know if you can disenroll at this time. If you can disenroll, we will also tell you the effective date of your disenrollment.

Until your disenrollment date, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <PDP name> may not pay for your prescriptions. After your disenrollment date, <PDP name> will not cover any prescription drugs you receive.

By disenrolling from <PDP name>, you are disenrolling from your Medicare prescription drug coverage. If you do not enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) at this time or you do not have or obtain *creditable prescription drug coverage (as good as Medicare's)* , you may have to pay a *late enrollment* penalty in addition to your premium for Medicare prescription drug coverage in the future. For information about the Medicare Plans available in your area, call Medicare at 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 have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Attachment

Exhibit 9 - PDP Model Disenrollment Form

Referenced in section: 40.1

Please fill out and carefully read all information below before signing and dating this disenrollment form. We will notify you of your effective date after we have received this form from you.

Last Name: First Name: Middle Initial:		☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Member ID:		
Birth Date:	Sex: ☐ M ☐ F	Home Phone Number: ( )

By completing this disenrollment request, I agree to the following:

<PDP name> will notify me of my disenrollment date after they receive this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at <PDP name> network pharmacies in order to receive my prescription benefit. I understand that there are limited times in which I will be able to join other Medicare Advantage or Medicare prescription drug plans, unless I qualify for a special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I do not have other coverage as good as Medicare, I may have to pay a *late enrollment* penalty for this coverage in the future.

Signature* _____ Date: _____

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

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

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

Exhibit 10 - PDP Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member

Referenced in section: 40.1.5

<Date>

Dear < Member>:

We received your request to disenroll from <PDP name>. You will be disenrolled starting <effective date>. Therefore, beginning <effective date>, <PDP name> will not cover any prescription drugs you receive.

Until <effective date>, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <PDP name> may not pay for your prescriptions.

If you have already enrolled in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage), you should receive confirmation of your enrollment from your new Plan. If you have not enrolled in another Medicare Plan, you should consider enrolling in one. If you do not enroll in a new Plan at this time or you do not have or obtain *creditable prescription drug coverage (as good as Medicare's)* , you may have to pay a *late enrollment* penalty if you enroll in Medicare prescription drug coverage in the future.

Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.

For information about the Medicare Plans available in your area, call Medicare at 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 have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 10a - PDP Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing

Referenced in section: 40.1.5

<Date>

Dear <Name of Member>:

This is to confirm your disenrollment from <PDP name>. Beginning <effective date>, <PDP name> will not cover any prescription drugs you receive.

If you have already enrolled in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage), you should receive confirmation of your enrollment from your new Plan. If you have not enrolled in another Medicare Plan, you should consider enrolling in one. If you do not enroll in a new Plan at this time or you do not have or obtain *creditable prescription drug coverage (as good as Medicare's)* , you may have to pay a *late enrollment* penalty if you enroll in Medicare prescription drug coverage in the future.

Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area *or if you receive extra help*. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.

For information about the Medicare Plans available in your area, call Medicare at 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 think you did not disenroll from <PDP name> and you want to stay a member of our Plan, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 11 - PDP Notice for Part D Plan Denial of Disenrollment

Referenced in section: 40.1.5

<Date>

Dear < Member>:

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

1. _____ You attempted to make a change to your Plan outside of an enrollment period. Medicare limits when and how often you can change your Medicare Plan.

2. _____ The request was made by someone other than the enrollee and that individual is not the enrollee's authorized representative.

Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 12 - PDP Model Notice for CMS Rejection of Disenrollment

Referenced in section: 40.1.5

<Date>

Dear < Member>:

Medicare has denied your disenrollment from <PDP name> because you have attempted to make a change to your Plan outside of an enrollment period. There are limits to when and how often you can change your Medicare Plan.

Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of <PDP name>'s service area. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.

If you believe this wrong, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 13 - PDP Model Notice of Disenrollment Due to Death

Referenced in section: 40.2.3

<Date>

To the Estate of < Member> :

Medicare has reported to us the death of <Name of Member>. Please accept our condolences.

< Member>'s coverage in <PDP name> has ended 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.

If this information is wrong, please contact your local Social Security office to have their records corrected. You can call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) from 7:00 am to 7:00 pm, Monday to Friday. If you have any questions, please call us at <phone number>. TTY/TDD users should call <TTY/TDD number>. We are open <days and hours of operation>. Thank you.

Exhibit 13a - PDP Model Notice for auto-enrollments provided by CMS with recent deceased code

Referenced in section: 30.1.4.D.

<Date>

To the Estate of < Member> :

Medicare has reported to us the death of <Name of Member>. Please accept our condolences.

We are sending this letter because Medicare had enrolled <Name of Member> in <PDP name>, a plan that provides Medicare prescription drug coverage. Because of this report of death, <Name of Member>'s coverage in <PDP name> ends as of <effective date>.

If this information is wrong, please contact your local Social Security office to have their records corrected. You can call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) from 7:00 am to 7:00 pm, Monday to Friday. If you have any questions, please call us at <phone number>. TTY/TDD users should call <TTY/TDD number>. We are open <days and hours of operation>. Thank you.

Exhibit 14 - PDP Model Notice of Disenrollment Due to Loss of Medicare

Referenced in section: 40.2.2

<Date>

Dear < Member>:

Medicare has told us that you no longer have Medicare <Insert A and/or B as appropriate>. Therefore, your membership in <PDP name> ended on <effective date>. If your plan premium was paid for any month after <effective date>, we will send you a refund within 30 days of this letter.

If this information is wrong, and you want to stay a member of our Plan, please contact us. Also, if you have not already done so, please contact your local Social Security office to have their records corrected. Or, you can call Social Security at 1-800-772-1213 from 7:00 AM to 7:00 PM, Monday to Friday. TTY users should call 1-800-325-0778.

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

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

Referenced in section: 50.2.1

<Date>

Dear < Member>:

The records for Medicare incorrectly show you as deceased.

If you have not already done so, please go to your local Social Security Office and ask them to correct your records. After you do this, please send us written proof at <address>. When we receive this proof, we will tell Medicare to correct their records.

In the meantime, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

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

Exhibit 16 - PDP Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Termination

Referenced in section: 50.2.1

<Date>

Dear < Member>:

On <date of request>, you told us that your enrollment in Medicare <insert Part A and/or Part B as appropriate> was ended in error and that you wanted to stay a member of <PDP name>. To do this, please complete the following steps:

1. Contact your local Social Security office and ask them to correct their records. Or, you can call Social Security at 1-800-772-1213 from 7:00 AM to 7:00 PM, Monday to Friday. TTY/TDD users should call 1-800-325-0778.

2. Ask Social Security to give you a letter that says they have corrected your records.

3. Send the letter from Social Security to us at: <address of PDP name> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we receive this letter, we will tell the Centers for Medicare & Medicaid Services to correct its records.

In the meantime, you should keep using <PDP name> network pharmacies to fill your prescriptions in order to receive prescription benefit coverage. If we learn that you do not have Medicare <insert Part A and/or Part B as appropriate>, you will have to pay for any prescription drugs you received after <disenrollment date>.

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

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

Exhibit 17 - PDP Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another PDP Organization

Referenced in section: 50.2.2

<Date>

Dear < Member>:

Thank you for letting us know you want to stay a member of < PDP name > after we sent you a letter that said we had disenrolled you from our Plan.

Based on what you told us, we understand that you cancelled your membership in the other Plan and want to stay a member of < PDP name >. Please send us a letter by <30 days from date of disenrollment notice> that says you want to stay a member of < PDP name >. Your letter must also say whether or not you filled any prescriptions at pharmacies outside of < PDP name >'s network since <original effective date of disenrollment>. You can mail your letter to us at <address>. Or you can fax it us at <fax number>.

In the meantime, you should continue using < PDP name > network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, < PDP name > may not pay for your prescriptions.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 18 - PDP Model Notice to Close Out Request for Reinstatement

Referenced in section: 50.2

<Date>

Dear < Beneficiary>:

We cannot process your request to be reinstated in < PDP name > because we have not received your letter asking for reinstatement. As discussed in our letter dated <date of letter>, you were required to send us this letter by <30 days from date of disenrollment notice> in order to remain a member of our Plan.

The <effective date> date of disenrollment remains in effect. If < PDP name > paid any costs for prescriptions you filled after <effective date>, we will bill you for the amount we paid.

Please remember that if you do not maintain Medicare prescription drug coverage or *creditable prescription drug coverage (as good as Medicare's)* , you may have to pay a *late enrollment* penalty if you enroll in Medicare prescription drug coverage in the future.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 19 - PDP Model Notice on Failure to Pay Plan Premiums - Advance Notification of Disenrollment

Referenced in section: 40.3.1

<Date>

Dear < Member>:

Our records show that we have not received payment for your < PDP name > plan premium as of <date>. If we do not receive payment by <insert last day of grace period>, we will have to disenroll you from < PDP name >. To avoid disenrollment, you must pay <amount due to avoid disenrollment> by <insert last day of grace period>. *If we do not receive your payment by <insert last day of grace period>, we will ask Medicare to disenroll you from < PDP name > beginning <effective date>.*

This letter pertains only to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits will not be affected if you are disenrolled from < PDP name**>.**

You *may be able to* submit a request to disenroll from < PDP name >. However, Medicare limits when you can disenroll from < PDP name > and when you can enroll in a new plan. Generally, you can *only* disenroll from < PDP name > (and enroll in a new plan) from November 15 through December 31 each year unless you meet certain special exceptions, such as if you move out of < PDP name >'s service area *or if you receive extra help in paying for your prescription drugs*. Also, if you do not 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 for Medicare prescription drug coverage in the future.

If you want to disenroll from < PDP name > now, you should do one of the following:

1. Send us a written request at <address>.
2. 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.. *TTY users should call 1-877-486-2048.*

If you think we have made a mistake, or if you have any questions, please contact < PDP name > customer service at <toll-free number>, <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.
Thank you.

Exhibit 20 - PDP Notice of Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment

Referenced in section: 40.3.1

<Date>

Dear < Member>:

On <date of notification letter>, we mailed you a letter stating that your Plan premium was overdue. The letter said that if you did not send your payment, we would disenroll you from < PDP name >. Since we did not receive that payment, we have asked Medicare to disenroll you. *Your disenrollment* from < PDP name > *will be effective* <effective date>. *After <effective date>, < PDP name > will not cover any prescription drugs you receive.*

This letter only pertains to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits are not affected by your disenrollment from < PDP name >.

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.

The Centers for Medicare & Medicaid Services limits when you can enroll in a new Medicare Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO).

Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of < PDP name >'s service area. **From November 15 through December 31 each year**, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year.

Please remember, if you disenroll and do not enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you do not 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.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank You.

Exhibit 21 - PDP Notice of Failure to Pay Plan Premium - Confirmation of Involuntary Disenrollment

Referenced in section: 40.3.1

<Date>

Dear < Member>:

Medicare has confirmed your disenrollment from < PDP name > due to non-payment of your Plan premium. Your disenrollment begins <effective date>. After <effective date>, < PDP name > will not cover any prescription drugs you receive.

This letter only pertains to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits are not affected by your disenrollment from < PDP name >.

The Centers for Medicare & Medicaid Services limits when you can enroll in a new Medicare Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO).

From November 15 through December 31 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare Health Plan for the following year. Please remember, if you do not have 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.

Generally, you may not enroll in a new Plan during other times of the year unless you meet certain special exceptions, such as if you move out of < PDP name >'s service area.

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.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 22 - Model Acknowledgement of Request to Cancel Enrollment Letter

Referenced in section: 50.1.1

<Date>

Dear < Member>:

As you requested, we have cancelled your enrollment with < PDP name >.

If you were enrolled in another Medicare Prescription Drug Plan or a Medicare Health Plan (such as a Medicare HMO or PPO) before enrolling with < PDP name >, you may appear on their records as being disenrolled. If you want to stay a member of that Plan, you will need to notify them that you enrolled in < PDP name > but have cancelled your enrollment. They may request a copy of this letter for their records.

Please remember that if you do not maintain Medicare prescription drug coverage or other coverage that is at least as good as Medicare's (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.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 23 - Model Acknowledgement of Request to Cancel Disenrollment Letter

Referenced in section: 50.1.2

<Date>

Dear < Member>:

As you requested, we have cancelled your disenrollment with < PDP name >. Thank you for your continued membership in our Plan.

You should continue to fill your prescriptions at < PDP name > network pharmacies. If you use an out-of-network pharmacy and there is not an emergency, < PDP name > may not pay for your prescriptions.

If you submitted an enrollment request to another Prescription Drug Plan or a Medicare Advantage Plan, you may appear on their records as being enrolled in their Plan. Since you have told us you want to stay enrolled in < PDP name >, you will need to contact the other Plan to ask them to cancel your enrollment before your enrollment takes effect. They may ask you to write them a letter for their records.

If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 24: PDP Model Notice to Confirm Auto-Enrollment

Referenced in section: 30.1.4 (*E*)

<Member # - *if member # is SSN, only use last 4 digits*>
<RxID>
<RxGroup>
<RxBin>
<RxPC*N*>

Dear <insert member name>

You are getting this letter because Medicare is enrolling you in our <PDP name>, and your coverage begins <effective date>. Medicare is also mailing you a yellow letter *about your enrollment*. *Please keep both letters for your records.*

> ***Important:*** *If you (or anyone on your behalf) have filled a prescription since <auto-enrollment effective date>, you may be able to get back some of these costs. Please contact us at <insert #> or visit <Plan website> on the web for more information.*

<***Optional language*****:** You can use **t**his letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us>

With this Medicare-approved plan, you pay :

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- $0for your yearly prescription drug plan deductible,
- <insert *applicable* copay *levels*> when you fill a prescription *covered by our plan*.

Remember, if Medicaid used to pay for your prescription drugs, Medicaid won't continue to cover the drugs it used to. Some state Medicaid programs may cover the few prescriptions that won't be covered under Medicare prescription drug coverage. But even if your state Medicaid program covers a few prescriptions, this coverage alone won't be as good as Medicare's (also referred to as "creditable coverage"). To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like [plan name].

If you have other types of prescription drug coverage, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veteran's Affairs, or a Medigap policy. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in a Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan. If you want to *join* a different Medicare prescription drug plan, call that plan to find out how to *join*. If you decide not to *join* any Medicare prescription drug plan, and don't have other drug coverage at least as good as Medicare's (also referred to as "creditable *prescription drug* coverage"), you may have to pay a *late enrollment* penalty *if you join* later. If you don't want Medicare prescription drug coverage, call our Member Services Department at <phone number>. TTY users should call <TTY number>. We are open {insert days/hours of operation and, if different, TTY hours of operation}. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or *visit* www.medicare.gov. TTY users should call 1-877-486-2048.

Thank you.

Exhibit 25: PDP Model Notice to Confirm Facilitated Enrollment

Referenced in section: 30.1.*4* (*E*)

<Member # - *if member # is SSN, only use last 4 digits*>
<RxID>
<RxGroup>
<RxBin>
<RxPC*N*>

Dear < member >

You are getting this letter because Medicare is enrolling you in our <PDP name> and your coverage begins <effective date>. Medicare is also mailing you a green letter *about your enrollment*. If you want coverage to begin earlier, you must tell us by <last day of month that is two months earlier than effective date>.

> ***Important:*** *If you (or anyone on your behalf) have filled a prescription since <facilitated-enrollment effective date>, you may be eligible for reimbursement for some of these costs. Please contact us at <insert #> or visit <Plan website> on the web for more information.*

[***Optiona****l*: You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

Because you qualify for extra help with your prescription drug costs, you will pay:

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert $0 or $5*3*> for your yearly prescription drug plan deductible,
- <insert copay amount or 15% coinsurance> when you fill a prescription *covered by our plan*.

If you have other types of prescription drug coverage, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veteran's Affairs, or a Medigap policy. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in a Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan. If you want to *join* a different Medicare prescription drug plan, simply call that plan to find out how to *join*. If you decide not to *join any Medicare prescription drug plan* and don't have other drug

coverage as good as Medicare's *(also referred to as "creditable prescription drug coverage")*, you may have to pay a *late enrollment* penalty *if you join later*. If you don't want Medicare prescription drug coverage, call our Member Services Department at <phone number>. TTY users should call <TTY number>. We are open {insert days/hours of operation and, if different, TTY hours of operation}. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or *visit* www.medicare.gov. TTY users should call 1-877-486-2048.

Thank you.

Exhibit 26 - PDP Acknowledgement of Request to Decline or Opt-Out of Part D

(Referenced in section 30.1.4 *(F)*
<Date>

Dear < Member>:

As you requested, < PDP name > has processed your request to decline (opt-out *of*) Medicare Prescription *d*rug *c*overage. Your decision to decline Medicare Prescription Drug Coverage doesn*'*t affect your enrollment in Medicare Part A or Part B *coverage*.

If you previously had drug coverage through Medicaid (Medical Assistance), that program will no longer pay for your prescription drugs. *Our records show that you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.*

Remember, like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy. If you don't join a Medicare drug plan when you are first eligible to join, and you haven't had coverage that is at least as good as Medicare's (also referred to as "creditable coverage") for 63 days or longer, you will have to pay a *late enrollment* penalty for late enrollment when you do join. You will have to pay *the* penalty *in addition to your premium* as long as you have Medicare prescription drug coverage.

If you have, or are eligible for other types of prescription coverage, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veteran's Affairs, or a Medigap policy. Talk to your benefits administrator, insurer, or plan provider. *Ask them if enrolling in a Medicare drug plan will hurt your other benefits.* You may not need to join a Medicare drug plan.

If you change your mind and decide you would like to *join*, please contact < PDP name > customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or *visit* www.medicare.gov. TTY users should call 1-877-486-2048

Thank you.

Exhibit 27 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region

Referenced in section: 40.2.1

<**Member # - *if member # is SSN, only use last 4 digits***>
<**RxID**>
<**RxGroup**>
<**RxBin**>
<**RxPC*N***>

<Date>

Dear < Member>:

You recently told us that you live in <*state*>. To make sure that you have Medicare prescription drug coverage where you live, we are enrolling you in <PDP name> that serves <insert states in the new plan's region>. Your new coverage will begin < effective date>.

If you disagree with the information in this letter or if you have any questions, please call customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

As a member of this plan, you will pay:

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert $0 or $5*3*> for your yearly prescription drug plan deductible,
- <insert *applicable* copayments] when you fill a prescription *covered by our plan*.

You aren't required to be in our Medicare prescription drug plan. If you want to *join* a different Medicare prescription drug plan, call a plan in your area to find out how to *join*. You can also call 1-800-MEDICARE (1-800-633-4227, which is open 24 hours a day, 7 days a week) or visit www.medicare.gov *on the web* to choose and join a plan *in your area that meets your needs*. TTY users should call 1-877-486-2048. If you decide not to be enrolled in any Medicare prescription drug plan, and don't have other drug coverage at least as good as Medicare's (also referred to as "creditable *prescription* coverage"), you may have to pay a *late enrollment* penalty to join later.

Thank you.

Exhibit 28 – Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor DOES NOT offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region

Referenced in section: 40.2.1

<Date>

Dear < Member>:

You recently told us that you live in a place where we do not provide Medicare prescription drug *plan with premiums fully covered by extra help*. You must live in <insert states where current PDP is offered> to be enrolled in <PDP name>. We have asked Medicare to disenroll you from < PDP name > beginning <effective date>.

It is important for you to call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) to choose and join a plan that serves your state *or territory*. TTY users should call 1-877-486-2048. If you want to learn about other plans you can join, call 1-800-MEDICARE or visit www.medicare.gov *on the web* for information about other Medicare drug plans available in your area.

If you disagree with the information in this letter or if you have any questions, please call customer service at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

Exhibit 29: Model Reassignment Confirmation

Referenced in section: 30.1.5 (D)

<Member # - if member # is SSN, only use last 4 digits>
<RxID>
<RxGroup>
<RxBIN>
<RxPCN

Dear < member >

You are getting this letter because Medicare has enrolled you in <PDP name> for coverage beginning January 1, <following calendar year>. You should have already received a blue letter from CMS telling you that they were moving you from the drug plan you were originally assigned to because either 1) that plan was leaving the Medicare program on December 31, <current calendar year>, or 2) the cost for that plan was increasing beginning January 1, <following calendar year>.

As of January 1, <following calendar year>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you don't and there is not an emergency, <PDP name> may not pay for your prescriptions.

[*Optional: You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.***]**

Because you qualify for extra help with your prescription drug costs, you will pay:

- *$0 per month for your < PDP name > premium,*
- *$0 for your yearly prescription drug plan deductible,*
- *<insert applicable LIS copay/coinsurance amount that will be charged in following calendar year> when you fill a prescription.*

To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>. However, you are don't have to be in our Medicare prescription drug plan. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join. If you decide not to be enrolled and don't have other drug coverage as good as Medicare's, (also referred to as "creditable prescription drug coverage"), you may have to pay a late enrollment penalty to join later. If you don't want Medicare prescription drug coverage, call our Member Services Department at <phone number>. TTY users should call <TTY number>. We are open [<days/times> 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 30: Optional Notice for "Losing Plan" to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC)

Dear < Member>:

Recently you may have received a blue letter from Medicare, telling you that they will switch you to another Medicare drug plan starting January 1, <following calendar year>. This is because it will cost you more if you stay in <current plan>.

The letter also said that you can stay in <current plan> in <following calendar year>. However, if you stay, you will pay a higher monthly premium in <following calendar year>. If you want more information to help you decide, please call our <Customer/Member> Services Department <days and hours of operation>, at <customer service toll-free number>. TTY users should call <TTY number> for the hearing impaired. We will send you more information about

- ***How your monthly premium would change for <following calendar year>***
- ***How your benefits and costs would change for <following calendar year>***
- ***What to do if your drug costs in <following calendar year>***

If you would like this information to help you decide or if you want to stay in <current plan>, call and let us know as soon as possible.

You can also get information about the Medicare Program and Medicare drug plans by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare customer service representatives are available, 24 hours a day, seven days a week, to answer questions about Medicare.

If you do nothing, your membership with us will end on December 31, *<current calendar year>****. You will get information from your new plan telling you about your benefits and any costs for <following calendar year>.***

Please let us know if you have any questions.

Sincerely,
<Plan Representative>

Exhibit 31: Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes

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

<Date>

Dear < 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 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 accessible and clear].*
- *Your enrollment in <Name of Plan> started on an earlier date. Your coverage will start <date>. [Include information about premiums and coverage here]*
- *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 on < date>. This means you 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.]*

Call <toll-free number> <days and hours of operation> to get more information. TTY users should call <toll-free TTY number>.

Thank you.