Medicare Managed Care Manual

Chapter 2 - Medicare Advantage Enrollment and Disenrollment

Update: ***July 16,*** **200*8***

This guidance update represents final CMS policy and is effective for contract year 2009, including all enrollments with an effective date on or after January 1, 2009. Please note that new Special Election Period (SEP) and clarifications to existing SEPs are effective immediately upon release of this new guidance. Organizations may implement other aspects of this guidance before the required implementation date.

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10 - Definitions

For Chapter 2, a reference to an "MA plan" includes MA local plans, MA Regional Preferred Provider Organization (PPO) plans and MA-PD plans (including special needs plans), unless otherwise specified.

The instructions provided in this chapter apply to MA plans, including MA-PD plans. Instructions for enrollment (and disenrollment) in a Prescription Drug Plan (PDP) or an 1876 cost plan are provided in a separate guidance.

The following definitions relate to topics addressed in this guidance.

Application Date – For paper enrollment forms and other enrollment *request* mechanisms, the application date is the date the enrollment request is initially received by the organization *as defined below. Plans must use this date in the appropriate field when submitting enrollment transactions to CMS. A summary of application dates for CMS enrollment transactions is provided in Appendix 3 of this guidance.*

- 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 fax is received on the organization's fax machine.
- For requests submitted to sales agents, including brokers, the application date is the date the agent/broker receives (accepts) the enrollment request *and not the date the organization receives the enrollment request from the agent/broker*. For purposes of enrollment, receipt by the agent or broker employed by or contracting with the plan is considered receipt by the plan*, thus all CMS required timeframes for enrollment processing begin on this date*.
- 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 have 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 is 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 all enrollments into employer group or union sponsored plans the application date used on the transaction submitted to CMS will always be the 1st of the month prior to the effective date of enrollment for all mechanisms at all times. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the organization receives*

the request. For example, if a valid group enrollment mechanism file is received by the organization on January 24th for enrollments effective February 1st, the receipt date for the provision of required notices is January 24th and the application date submitted on the enrollment transactions is January 1st.

- For auto- or facilitated enrollment, as described in §*40.1.5*, the application date is the 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.
- *In limited circumstances, CMS may require MA organizations to submit crosswalk (i.e. "rollover") transactions as part of the transition from one contract year to another. In these cases, the MA organization must have approval from their RO Account Manager and CMS Division of Payment Operations (DPO) representative prior to submitting these transactions. When approved, the application date must be set to November 14th of the current year, with an effective date of the following January 1st and the election period identifier value of "X."*

Cancellation of *Enrollment Request* - An action initiated by the beneficiary to cancel an *enrollment request* before the effective date of the election. A cancelled *enrollment request* has not been used and *the election* remains available for use during the applicable election period.

Completed Election - An *enrollment request* is considered complete when:

1. The form/request is signed by the beneficiary or legal representative (refer to §40.2.1 for a discussion of who is considered to be a legal representative), or the *enrollment request* mechanism is completed;

2. For enrollments, evidence of entitlement to Medicare Part A and enrollment in Medicare Part B is obtained by the Medicare Advantage organization (see below for definition of "evidence of Medicare Part A and Part B coverage");

3. All necessary elements on the form are completed (for enrollments, see Appendix 2 for a list of elements that must be completed) or when the *enrollment request* mechanism is completed as CMS directs, and, when applicable;

4. Certification of a legal representative's authority to make the *enrollment request* is obtained by attestation (refer to §40.2.1).

If an individual is involuntarily disenrolled for failure to pay premiums, to re-enroll in that plan, or enroll into another, he or she would need to request enrollment during a valid enrollment period. In addition, for enrollments into an MA-only (non MA-PD) plan, an MA organization may also choose to wait for the individual's payment of the plan premium, including any premiums due the MA organization for a prior enrollment before considering an enrollment "complete."

Continuation Area/Continuation of Enrollment Option - A continuation area is an additional CMS-approved area outside the MA local plan's service area within which the

MA organization furnishes or arranges for furnishing of services to the MA local plan's continuation of enrollment members. MA organizations have the option of establishing continuation areas for MA local plans.

Conversions - For individuals who are enrolled in a health plan offered by the MA organization the month immediately before the month of their entitlement to Medicare Parts A and B, their enrollment in an MA plan offered by the same organization is referred to as a "conversion" from non-Medicare status to MA enrollee status. In order for the individual's enrollment with the organization as an MA enrollee to take effect upon becoming eligible for Medicare, conversions must take place during the individual's Initial Coverage Election Period (ICEP).

Denial of *Enrollment Request* - Occurs when an MA organization determines that an individual is not eligible to make an *enrollment request* (e.g., the individual is not entitled to Medicare Part A or enrolled in Part B, the individual has ESRD, the individual is not making the *enrollment request* during an election period, etc.), and therefore determines it should not submit the *enrollment request* transaction to CMS.

Election - Enrollment in, or voluntary disenrollment from, an MA plan or the traditional Medicare fee-for-service program ("Original Medicare") constitutes an election. (Disenrollment from Original Medicare would only occur when an individual enrolls in an MA plan.) The term "election" is used to describe either an enrollment or voluntary disenrollment. If the term "enrollment" is used alone, however, then the term is used deliberately, i.e., it is being used to describe only an enrollment, and not a disenrollment. The same applies when the term "disenrollment" is used alone, i.e., the term is being used to describe only a disenrollment, and not an enrollment.

***Enrollment Request* Form -** An *enrollment request* mechanism used by individuals to request to enroll in, or disenroll from, MA plans. *Several* model individual enrollment form*s are* provided in *the Exhibits at the end of this guidance*. **An individual who is a member of an MA plan and who wishes to elect another MA plan, even if it is in the same MA organization, must complete a new election *during a valid enrollment period* to enroll in the new MA plan**. However, that individual may use a short enrollment form (refer to Exhibit 3) or a "plan selection" form (refer to Exhibit 3a) to make the election in place of the comprehensive individual enrollment form, or, may complete the election via the Internet, as described in §40.1.3 of this guidance, or by telephone, as described in §40.1.4 of this guidance, if the MA organization offers these options. In addition, MA organizations may want to collaborate with Employer/Union Group Health Plans (EGHPs) (see definition below) to use a single enrollment form (or other CMS approved method, if available) for EGHP members; a model EGHP enrollment form for this purpose is provided in Exhibit 2. Beneficiaries or their legal representatives must complete an enrollment *request* mechanism (e.g. enrollment form) to enroll in an MA plan.

Beneficiaries are not required to use a specific form to disenroll from an MA plan; however, a model disenrollment form is provided in Exhibit 10.

Election Period - The time(s) during which an eligible individual may elect an MA plan or Original Medicare. The type of election period determines the effective date of MA coverage. There are several types of election periods, all of which are defined under §30.

Evidence of *Entitlement (*Medicare Part A and Part B Coverage*)* - For the purposes of completing an enrollment *request*, the MA organization must verify Medicare entitlement for all enrollment requests using either the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen). Therefore, the applicant is not required to provide evidence of entitlement to Medicare Part A and enrollment in Part B with the enrollment request.

If CMS systems do not show Medicare entitlement, the organization must consider the individual's Medicare ID card as evidence of Medicare entitlement. If CMS systems do not show Medicare entitlement and the individual's Medicare ID card is not available, the organization must consider an SSA award letter that shows the Medicare HICN and effective date of Part A/B as evidence of Medicare entitlement.

Evidence of Permanent Residence - A permanent residence is normally the enrollee's primary residence. An MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills to verify the primary residence. Such records must establish the permanent residence address, and not the mailing address, of the individual.

Full-Benefit Dual Eligible Individual – For purposes of Medicare Prescription Drug benefits (Part D), is a Medicare beneficiary who is determined eligible by the state for medical assistance for full benefits under title XIX of the Social Security Act for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act, or medical assistance under section 1902(a)(10)(C) of the Act (medically needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

Institutionalized Individual - An individual who resides in an institution:

- 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 referred to 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 which has an agreement under §1883 of the Act (a swing-bed hospital).

Involuntary Disenrollment - Refers to when an MA organization, as opposed to the member, initiates disenrollment from the plan. Procedures regarding involuntary disenrollment are found in §§50.2 and 50.3.

Medicare Advantage Organization (MA organization) - Refer to Chapter 1 (General Provisions) for a definition of an "MA organization."

MA Organization Error - An error or delay in *enrollment request* processing made under the full control of the MA organization personnel and one that the organization could have avoided.

Medicare Advantage Plan - Refer to Chapter 1 for a definition of "MA plan." *Enrollment request*s are made at the MA **plan level**, not at the **MA organization level.**

Other Low Income Subsidy (LIS) Eligible Individuals – For purposes of Medicare Part D benefits, individuals who are determined eligible for the Part D low-income subsidy (LIS) who are not full-benefit dual eligible individuals as defined above. This includes individuals deemed eligible for LIS by virtue of having QMB-only, SLMB-only, QI, SSI-only; as well as those who apply and are determined eligible for LIS.

Out-of-Area Members - Members of an MA plan who live outside the service area and who elected the MA plan while residing outside the service area (as allowed in §§20.0, 20.3, 50.2.1, and 50.2.4).

Receipt of *Enrollment Request* - MA organizations may receive *enrollment requests* through various means, as described in §40.1 and in §50.1 for disenrollment requests. The MA organization must date as received all *enrollment request*s as soon as they are initially received. *T*his date will be used to determine the election period in which the request was made, which in turn will determine the effective date of the request. *Please refer to the definition of "Application Date" in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.*

Reinstatement of Election - An action that may be taken by CMS to correct an erroneous disenrollment from an MA plan. The reinstatement corrects an individual's records by canceling a disenrollment to reflect no gap in enrollment in an MA plan. A reinstatement may result in retroactive disenrollment from another Medicare managed care plan.

Rejection of *Enrollment Request* - Occurs when CMS has rejected an *enrollment request* submitted by the MA organization. The rejection could be due to the MA organization incorrectly submitting the transactions, to system error, or to an individual's ineligibility to elect the MA plan.

Special Needs Plan – Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including; institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and other chronically ill or disabled beneficiaries as provided by CMS.

System Error - A "system error" is an unintended error or delay in *enrollment request* processing that is clearly attributable to a specific Federal government system (e.g., Social Security Administration (SSA) system, Railroad Retirement Board (RRB) system), and is related to Medicare entitlement information or other information required to process an *enrollment request*.

20 - Eligibility for Enrollment in MA Plans

42 CFR 422.50

In general, an individual is eligible to elect an MA plan when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan (see exceptions described under §20.6);

2. The individual has not been medically determined to have ESRD prior to completing the enrollment *request* (see exceptions described under §20.2);

3. The individual permanently resides in the service area of the MA plan (see exceptions in §20.3 for persons living outside the service area at the time of *the enrollment request*);

4. The individual or his/her legal representative completes an enrollment *request* and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS (refer to Appendix 2 for a list of items required to complete the enrollment form, and §40.2.1 for who may sign *enrollment request* forms or complete other *enrollment request* mechanisms);

5. The individual is fully informed of and agrees to abide by the rules of the MA organization that were provided during the *enrollment request*; and

6. The individual makes a valid *enrollment request that is received by the plan* during an election period, as described in §30;

7. For a Special Needs Plan (SNP) additional requirements apply as described in §20.11 of this guidance.

8. *For an MSA plan, additional requirements apply as described in §20.10 of this guidance.*

An MA organization may not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in this guidance.

An MA organization must not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in an MA plan and continues to be enrolled in his/her employer/union or spouse's group health benefits plan, then coordination of benefits rules apply.

An MA eligible individual may not be enrolled in more than one MA plan at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described *in* §*§60.1, 60.2 and* 60.3.

Individuals enrolled in an MA plan may not concurrently enroll in a PDP except for individuals enrolled in a Medicare MSA plan or individuals enrolled in a PFFS plan that

does not offer Medicare prescription drug coverage. An individual enrolled in an MA PFFS plan that does not include a Part D benefit may enroll in a PDP, even if under the same MA contract the organization offers another PFFS plan that includes a Part D benefit.

20.1 - Entitlement to Medicare Parts A and B *and Eligibility for Part D*

To be eligible to elect an MA plan, an individual must be entitled to Medicare Part A and enrolled in Part B, and must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the plan. Exceptions for Part B-only "grandfathered" members are outlined in §20.6. Part B only individuals currently enrolled in a plan created under §1833 or §1876 of the Social Security Act (the Act) are not considered to be "grandfathered" individuals, and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an MA plan.

An MA organization has the option to continue to offer Part A-equivalent coverage to Medicare Part B-only "grandfathered" members, as described in §20.6. However, an MA organization may not offer Part A-equivalent coverage to other individuals enrolled only in Medicare Part B (and not entitled to Part A) in order to make them "eligible" for enrollment in an MA plan. Eligibility requirements are met based on Part A entitlement through Medicare and not through the purchase of Part A-equivalent benefits through the MA organization. The MA organization may refer the individual to SSA if the individual wishes to enroll in Medicare Part A in order to be eligible to enroll in the MA plan.

Eligibility for Part D does not exist:

- *When the beneficiary is incarcerated.*
- *When the beneficiary lives abroad.*
- *For any month prior to the month of notification of the entitlement determination when the entitlement determination for Part A and B is made retroactively.*

MAPDs may not enroll an individual who is not eligible for Part D.

20.2 - End-Stage Renal Disease (ESRD)

Except as provided under exceptions discussed below, an individual is not eligible to elect an MA plan if he/she has been medically determined to have ESRD. ESRD means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. A Medicare beneficiary will be assigned ESRD status by the Medicare ESRD system as a result of the attending physician certifying the ESRD status of the enrollee and completing a CMS Form CMS-2728-U3. For purposes of MA eligibility, an individual's ESRD status begins:

- The date regular dialysis begins, as reported on the Form CMS-2728-U3; or
- The month an individual is admitted to a hospital for a kidney transplant, or for health care services needed before a transplant if the transplant takes place in the same month or within the two following months; or

- The first day of the month dialysis began if the individual trained for self-dialysis.

An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. Such an individual may elect to enroll in a MA plan, if he/she meets other applicable eligibility requirements. If an individual is only eligible for Medicare on the basis of ESRD (i.e., not based on disability or age), the individual would only be permitted to remain enrolled as an MA enrollee during his or her remaining months of Medicare eligibility.

In addition, an individual who initiated dialysis treatments for ESRD, but subsequently recovered native kidney function and no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. Such an individual may also elect to enroll in a MA plan, if he/she meets other applicable eligibility requirements.

The MA organization is permitted to ask at the time of the *enrollment request* whether the applicant has ESRD. This question is not considered impermissible health screening since the law does not permit a person with ESRD to elect an MA plan, except as provided in the following paragraphs. If a beneficiary no longer requires regular dialysis or has had a successful transplant, the beneficiary should obtain a note or records from the beneficiary's physician showing that the ESRD status has changed and submit it with the enrollment election. An MA organization must deny enrollment to any individual medically determined to have ESRD, except as provided in the following paragraphs. The CMS will reject the enrollment if Medicare records indicate the applicant has ESRD, and no exception permitting enrollment applies.

Procedures for identifying whether an individual is medically determined to have ESRD are included in §40.2.4.

20.2.1 - Background on ESRD Entitlement

When an individual files for Medicare based upon ESRD, entitlement can begin:

- The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis);

- The first day of the month dialysis began if the individual trains for self-dialysis;

- The month an individual is admitted to a hospital for a kidney transplant, or for health care services needed before a transplant if the transplant takes place in the same month or within the two following months;

- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before); or

- Prospectively.

The Medicare entitlement date is usually the month an individual receives a transplant or three months after the month the individual begins dialysis (i.e., the first day of the fourth month of dialysis). For example, if an individual begins dialysis in January, Medicare entitlement is effective April 1. Therefore, for these individuals, the initial coverage election period (ICEP) would be the time between when dialysis begins and the Medicare entitlement date - the 3-month waiting period for Medicare entitlement.

There are individuals who are approved to perform **self-dialysis**. If an individual is approved for self-dialysis, SSA will waive the 3-month waiting period to begin Medicare entitlement. In cases of self-dialysis, Medicare entitlement is effective the month dialysis begins, rather than the customary 3 months from the month the individual begins dialysis.

EXAMPLE

A Medicare record is established in January for an April 1 entitlement effective date. Since the individual has 3-month waiting period waived, SSA submits a changed record for a January 1 Medicare entitlement effective date.

Medicare pays nothing until the individual files for benefits and Medicare coverage becomes effective.

Individuals sometimes elect a prospective effective date to coordinate with the end of their 30-month coordination period. In the case of an **individual in a group health plan**, the group plan is required to be the primary payer for the first 30 months of Medicare eligibility or entitlement (also known as the 30-month coordination of benefits period), as long as the individual chooses to be enrolled in the group health plan. There is nothing to require an individual to file for Medicare immediately upon starting dialysis. The group health plan is primary during the coordination of benefits period, without regard to the number of individuals employed and irrespective of current employment status.

Since an ICEP generally relates to when an individual becomes entitled to Medicare Part A and B, when possible the group or MA organization should coordinate with the individual so that he/she will not be adversely impacted if he/she has the option to elect an MA plan.

20.2.2 - Exceptions to Eligibility Rule for Persons Who Have ESRD

1. Conversions upon ICEP: Individuals who developed ESRD while a member of a health plan offered by an MA organization and who are converting to Medicare Parts A and B, can elect an MA plan in the same organization (within the same State, with exceptions) as their health plan during their ICEP. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.) The individuals must meet all other MA eligibility requirements and must fill out an *enrollment request* form or complete an alternate enrollment *request* to join the MA plan.

2. Conversions other than ICEP:

   (a.) If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan

during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an MA plan offered by the MA organization, as long as they were enrolled in a health plan offered by the same MA organization the month before their entitlement to Parts A and B, developed ESRD while a member of that health plan, and are still enrolled in that health plan. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period **after** dialysis begins.

These individuals will be given a special election period. See §30.4.4 for additional instructions.

(b.) Individuals who develop ESRD while enrolled in a health plan (e.g., a commercial or group health plan, or a Medicaid plan) offered by the MA organization are eligible to elect an MA plan offered by that organization. In order to be eligible, there must be no break in coverage between enrollment in the health plan offered by an MA organization, and the start of coverage in the MA plan offered by the same organization.

3. An individual who elects an MA plan and who is medically determined to first have ESRD **after** the date on which the enrollment form is signed (or receipt date stamp if no date is on the form, per §40.2), or the *enrollment request* is made by alternate means provided by CMS, but **before** the effective date of coverage under the plan is still eligible to elect the plan.

4. An individual who develops ESRD while enrolled in an MA plan may continue to be enrolled in the MA plan.

5. Once enrolled in an MA plan, a person who has ESRD may elect other MA plans in the same MA organization (and during allowable *enrollment request* periods, as described under §30.). However, the member would not be eligible to elect an MA plan in a different MA organization or a plan in the same MA organization in a different State (with exceptions).

6. An individual with ESRD whose enrollment in an MA plan was terminated on or after December 31, 1998, as a result of a contract termination, non-renewal, or service area reduction can make one *enrollment request* into a new MA plan. The individual must meet all other MA eligibility requirements, and must enroll during an MA election period described in §30, which includes the SEP associated with that specific termination, non-renewal or service area reduction. Once an individual has exhausted his one election, he/she will not be permitted to join another MA plan, unless his new plan is terminated.

7. Individuals with ESRD may enroll in an SNP that has obtained a waiver to be open for enrollment to individuals with ESRD.

20.2.3 - Optional Employer/Union Group Waiver for ESRD Enrollees

The MA organizations may choose to accept enrollees with ESRD who are enrolling in an MA plan through an employer or union group under the following circumstances:

1. If an employer or union group offers an MA plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, beneficiaries with ESRD who are otherwise eligible may select this new MA plan option as the employer or union's open enrollment rules allow.

2. If an employer or union group that has been offering a variety of coverage options consolidates its employee/retiree offerings (i.e., it drops one or more plans), current enrollees of the dropped plans may be accepted into an MA plan that is offered by the group.

3. If an employer or union group has contracted locally with an MA organization in more than one geographic area (for example, in two or more states), beneficiaries with ESRD who relocates permanently from one geographic location to another may remain with the MA organization in the local employer or union MA plan.

4. If an employer or union group beneficiary with ESRD ages into Medicare, he/she may enroll in an employer or union sponsored MA plan regardless of prior commercial coverage.

In order to accommodate these four scenarios, we are waiving the regulations at 42 CFR 422.50(a)(2).

The MA organizations that choose to apply this waiver must agree to apply it consistently. Each year, MA organizations may choose whether or not to apply this waiver at the time of their renewal.

20.3 - Place of Permanent Residence

An individual is eligible to elect an MA plan if he/she permanently resides in the service area of the MA plan. For purposes of enrollment in a Part D plan *(including MA-PD plans)*, incarcerated individuals are to be considered as residing out of the plan service area, even if the correctional facility is located within the plan service area. A temporary move into the MA plan's service area does not enable the individual to elect the MA plan; the MA organization must deny such an *enrollment request*.

EXCEPTIONS

- An MA organization may offer a continuation of enrollment option to MA local plan enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the MA organization as a continuation area (refer to §60.*8* for more detail on the requirements for the continuation of enrollment option).

- Conversions: Individuals who are enrolled in a health plan of the MA organization and are converting to Medicare Parts A and B can elect an MA local plan offered by the same MA organization during their ICEP even if they reside in the MA organization's continuation area. ("Conversion" is defined in §10 and the time frames for the ICEP are covered in §30.2.)

- A member who was enrolled in an MA plan covering the area in which the member permanently resides at the time the plan was terminated in that area, may remain enrolled in the MA plan while living outside the plan's new reduced service area if:

    - There is no other MA plan serving the area at that time;

    - The MA organization offers this option; and

    - The member agrees to receive services through providers in the MA plan's service area.

- The MA organization has the **option** to also allow individuals who are converting to Medicare Parts A and B to elect the MA plan during their ICEP even if they reside outside the service **and** continuation area. This option may be offered provided that CMS determines that all applicable MA access requirements in 42 CFR 422.112 are met for that individual through the MA plan's established provider network providing services in the MA plan service area, and the organization furnishes the same benefits to the individual as to members who reside in the service area. The organization must apply the policy consistently for all individuals. These members will be known as "out-of-area" members. This option applies both to individual members and to employer or union sponsored group plan members of the MA organization.

Individuals who do not meet the above requirements may not elect the MA plan. The MA organization must deny enrollment to these individuals.

A permanent residence is normally the primary residence of an individual. Proof of permanent residence is normally established by the address of an individual's residence, but an MA organization may request additional information such as voter's registration records, driver's license records (where such records accurately establish current residence), tax records, and utility bills. 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 form, the MA organization must contact the individual to confirm that the individual resides in the service area. If there is a dispute over where the individual permanently resides, the MA organization should determine whether, according to the law of the MA organization's 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.

*MA organizations have the **option** to offer "visitor" or "traveler" programs for currently enrolled individuals who are consecutively out of the area for up to 12 months, provided the plan includes the full range of services available to other members (refer to §50.2.1 for more detail on the requirements for the "visitor/traveler" option). Residence in an area designated for a "visitor" or "traveler" program does not make an individual eligible to enroll in an MA plan, but rather applies to already enrolled individuals.*

20.3.1 - State and County Code (SCC) Corrections

In order to validate a request for a retroactive payment adjustment, the MA organization is required to provide evidence that establishes an individual's place of permanent residence for that specific period of time. This is different from the process outlined in §20.3 above that provides instructions for establishing current residence for the purposes of eligibility to enroll, or remain enrolled, in an MA plan.

Some evidence items that are acceptable for establishing current residence may not be acceptable for establishing residence for a past period of time. For example, a driver's license generally does not specify a period of time in which the address presented on it is or was valid, and there are variances among the states regarding updating their records when a change of address occurs. Since a driver's license may not provide adequate verification of residence for a specific, past period of time in all states, it is not considered acceptable documentation for retroactive payment adjustment requests. In contrast, a signed statement from the beneficiary, or his or her representative, that confirms the residence for the specific period, or a tax record covering the period in question are examples of documents that do address the specific period of time associated with a retroactive payment adjustment for SCC discrepancies and as such, constitute acceptable documentation.

Information on SCC discrepancies and payment corrections, including evidence requirements for retroactive payment adjustments, is provided in Chapter 19 of the Medicare Managed Care Manual.

20.3.2 – Mailing Address

As described in §20.3, an individual's eligibility to enroll in an MA plan is in part determined by the individual's permanent residence in the service area of that MA plan. Some individuals may have separate mailing addresses that may or may not be within the geographic plan service area. If an individual requests that mail be sent to an alternate address, such as that of a relative for example, MA organizations should make every effort to accommodate these requests, and should use this address to provide the required notices in this guidance and other plan mailings as appropriate. The model MA plan enrollment application forms provided in this guidance include a mechanism to collect alternate mailing address. Use of an alternate mailing address does not eliminate or change the requirement of residency for the purposes of MA plan eligibility.

20.4 - Completion of Enrollment *Request*

An eligible individual or the individual's legal representative (as described in §40.2.1) must complete an *enrollment request* to enroll in an MA plan, **even if that individual is electing an MA plan in the same MA organization in which he/she is enrolled**. Unless otherwise specified by CMS, an eligible individual can elect an MA plan only if he/she completes an enrollment *request*, provides required information to the MA organization within required time frames, and submits the properly completed *enrollment request* to the MA organization for enrollment *during a valid enrollment period*. Model enrollment forms are included in Exhibits 1, 1b, *1c*, 2, and 3.

An individual who is a member of an MA plan, and who wishes to elect another MA plan offered by the same MA organization, must complete a new enrollment *request during a valid enrollment period* to enroll in the new MA plan; however, that individual may use a short enrollment form (refer to Exhibit 3 for a model short enrollment form or Exhibit 3a for a model plan selection form) to make the *enrollment request* in place of the comprehensive individual enrollment form, or may complete the *enrollment request* via the Internet, as described in §40.1.3 of this chapter, or by telephone, as described in §40.1.4 of this chapter, if the MA organization offers these options.

An MA organization must deny enrollment to any individual who does not properly complete the enrollment form or other mechanism within required time frames. Procedures for completing the enrollment request are provided in §40.2 and Appendix 2. Refer to §10 for a definition of "completed *enrollment request*."

20.4.1 - Optional Employer/Union *Enrollment Request* Mechanism

Beginning April 1, 2003, MA organizations that offer MA plans to an employer or union may choose to accept voluntary *enrollment request*s directly from the employer or union (or its TPA) without obtaining a paper MA *enrollment request* form from each individual. The *enrollment request*s reported to the MA organization by the employer/union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan. This *enrollment request* mechanism is optional for MA organizations, and may not be required. Therefore, MA organizations may specify the employers and/or unions, if any, from which they will accept this *enrollment request* format and may choose to accept enrollment and/or voluntary disenrollment *request*s.

The record of an individual's choice of health plan submitted by the employer or union effectively replaces the paper MA *enrollment request* form(s). All eligibility, processing and notice requirements, as outlined in this guidance and other references, that pertain to paper *enrollment request* forms are applicable to this *enrollment request* mechanism; however, this process does not require the MA organization to obtain a signature. Detailed information and instruction is provided in §40.1.2 for enrollments and §50.1.5 for disenrollments.

Notices of disenrollment, cancellation or termination of coverage not initiated by an enrollee *enrollment request* (i.e. involuntary disenrollment) are not included in this mechanism. Guidance for these situations is available in §50.1.5.

20.4.2 - Passive *Enrollment Requests*

Under Medicare laws and regulations, Medicare beneficiaries must make an *enrollment request* to enroll in an MA plan, and CMS specifies the form and manner in which such *enrollment request*s are made. CMS has determined that it is legally permissible to provide for enrollment in an MA plan under a passive *enrollment request* process in specific, limited circumstances generally associated with the MA plan renewal process. A passive *enrollment request* is defined as a process by which a beneficiary is informed that he or she may make an *enrollment request* of a new MA plan by taking no action.

MA Plan Renewal and Non-Renewal

When a passive *enrollment request* is used in connection with a Service Area Reduction (SAR) or plan termination, the MA Organization must send a modified Annual Notice Of Change (ANOC) to the enrollees setting forth the available options, including Medigap rights. Although the ANOC information ordinarily may not be due until a later date, the MA organization must provide the ANOC information for the new MA Plan by October 2 of the current calendar year for the following year's plan(s). This will satisfy the MA Plan termination notification requirements and give the enrollees time to decide whether to elect the new plan by taking no action.

When a passive *enrollment request* is used in an MA plan renewal that **does not** include a termination or SAR, there are no Medigap rights. The MA Organization should use the regular ANOC and include passive enrollment language to inform enrollees about their respective plans and other choices for the upcoming year.

20.4.3 - Group Enrollment for Employer or Union Sponsored Plans

CMS is providing a process for group enrollment into an employer/union sponsored MA plan. CMS will allow an employer or union to enroll its retirees using a group enrollment process *in which the beneficiaries participate through advance notification and* that provides CMS with any information the employer/union has on other insurance coverage for the purposes of coordination of benefits. MA organizations must adhere to the guidelines outlined in §40.1.*6*, as well as all other program requirements, in developing and implementing this process.

20.5 - Agreeing to Abide by MA Organization Rules

An individual is eligible to elect an MA plan if he/she is fully informed of and agrees to abide by the rules of the MA organization that were provided during the enrollment process (refer to §§40.4, 40.4.1, and 40.4.2 regarding what information must be provided to the individual during the enrollment process). "Fully informed" means that the individual must be provided with the applicable rules of the MA organization, as described in §40.4.1 of this chapter, as well as in the Medicare Marketing Guidelines. The MA organization must deny enrollment to any individual who does not agree to abide by the rules of the MA organization. Agreement to abide by the rules of the MA organization in this context is made through the completion of the enrollment *request*.

20.6 - Grandfathering of Members on January 1, 1999

An individual who was enrolled on December 31, 1998, in an HMO with a risk contract under §1876 of the Social Security Act was deemed to be enrolled on January 1, 1999, in an MA plan offered by the same organization if he/she did not choose to disenroll from the organization effective on the latter date. This deemed enrollment applied even if the enrollee was not entitled to Medicare Part A or did not live in an MA plan service area or continuation area. The MA organization was not permitted to disenroll such individuals because they were not entitled to Part A, or did not live in the service or continuation area. However, if these individuals elect to disenroll from the MA organization, they are not eligible to enroll in any MA plan until or unless they meet all MA eligibility requirements.

If enrollment in Medicare Part B ends for an individual, the individual may not continue as a member of the MA plan and must be disenrolled as described in §§50.2.2 and 50.6.

The MA organization must identify all Medicare Part B-only "grandfathered" individuals and inform them of their status annually. This notification may be included as part of the Evidence of Coverage. The notice must inform these individuals that if they disenroll from the MA organization, they cannot elect another MA plan unless they become entitled to Medicare Part A (by enrolling in Medicare Part A at SSA and by paying the appropriate premium to CMS) and remain enrolled in Medicare Part B.

MA organizations may continue to provide Part A-equivalent benefits to Medicare Part B-only grandfathered members. In addition, if an MA organization offers Part A-equivalent coverage as a supplemental benefit in an MA plan, then the MA organization may disenroll a Medicare Part B-only grandfathered member who fails to pay the organization's Part A-equivalent premium, just as any member of the MA organization could be disenrolled for nonpayment of premiums (refer to §50.3.1).

Grandfathered members may enroll in other MA plans in the same MA organization (within the same State, with exceptions). However, if grandfathered members disenroll from the MA organization (i.e., they switch to Original Medicare), they will not be eligible to enroll in any MA plan in any MA organization until or unless they meet all MA eligibility requirements. If the out-of-area grandfathered members disenroll from the MA organization (i.e., they switch to Original Medicare or attempt to enroll in another MA organization), they will only be able to enroll in other MA organizations if they meet all MA eligibility requirements, including, but not limited to, that of living in the service area of the MA plan.

20.7 - Eligibility and the Hospice Benefit

An MA organization must not deny enrollment to any individual who has elected the hospice benefit (except in the case of a Medicare MSA plan; see §20.10 for additional eligibility requirements for Medicare MSA plans). Until the MA organization acknowledges that it has received the completed enrollment *request* and gives a coverage effective date to the individual (refer to Exhibit 4, Exhibit 4a, and §40), the MA organization must not ask any questions related to the existence of a terminal illness or

election of the hospice benefit. Such questions will be considered impermissible health screening.

The MA organization may not disenroll any member on the basis of the member electing the hospice benefit either before or after becoming a member of the MA plan.

20.8 - Continuation of Enrollment Option for MA Local Plans

With CMS approval, an MA organization may establish continuation areas, separate and apart from an MA local plan's service area. Refer to Chapter 11 (Contracts with Medicare + Choice Organizations) regarding CMS approval of continuation areas. As defined in §10, the CMS-approved continuation area is an additional area outside an MA local plan's service area within which the MA organization furnishes or arranges for furnishing of services to the MA plan's members. Members may only choose to continue enrollment with the MA local plan if they have permanently moved from the service area into the continuation area.

As described in Chapter 11, if an MA organization wants to offer a continuation of enrollment option under one or more of the MA local plans it offers, then it must obtain CMS' approval of the continuation area and the marketing materials that describe the continuation of enrollment option. The MA organization must also describe the enrollment option(s) in member materials and make the option available to all members of the MA local plan in question who make a permanent move to the continuation area. An MA organization may require members to give advance notice of their intent to use the continuation of enrollment option. If the MA organization has this requirement, then it must fully describe the required notification process in the CMS-approved marketing materials. In addition, the MA organization must fully explain any continuation option to all potential members of the MA local plan, current members of any other health plan of the MA organization members who reside in the MA local plan service area and/or MA organization continuation area.

If a member who permanently moves from the service area into the continuation area does not choose the continuation of enrollment option when he/she is eligible for the option, then the individual is no longer eligible to be a member of the MA local plan, and the MA organization must initiate the individual's disenrollment. Procedures for continued enrollment are in §60.8 and procedures describing disenrollment for permanent change of residence are described in §50.2.1.

20.9 - Additional Eligibility Requirements for MA Religious Fraternal Benefit (RFB) Plans

An MA RFB plan is a plan that an RFB society may offer only to members of the church, or convention or group of churches with which the society is affiliated. The requirement for membership can be met by any documentation establishing membership issued by the church, or by using the church's records of membership. An individual must also meet all the other requirements to elect an MA plan.

20.10 - Eligibility Requirements for Medicare Medical Savings Account (MSA) Plans

There are additional requirements and limitations for individuals who wish to elect a Medicare Medical Savings Account (MSA) plan. An individual is not eligible to elect a Medicare MSA plan if any one of the following applies:

- The individual will reside in the United States for fewer than 183 calendar days during the year in which the *enrollment request* is effective;
- The individual is enrolled in a Federal Employees Health Benefits program, or is eligible for health care benefits through the Department of Veterans Affairs or the Department of Defense;
- The individual is *dual eligible and is* entitled to coverage of Medicare *premium and/or* cost-sharing under a Medicaid State plan;
- The individual is receiving hospice benefits under the Medicare benefit prior to completing the enrollment *request*; or
- The individual receives health benefits that cover all or part of the annual Medicare MSA deductible such as through insurance primary to Medicare, supplemental insurance policies not specifically permitted under 42 CFR 422.104, or retirement health benefits.

20.11 - Additional Eligibility Requirements for MA Special Needs Plans

MA Special Needs Plans (SNP) may limit enrollment to individuals who meet specified eligibility requirements in addition to the eligibility requirements in §20 of this chapter. To be eligible for enrollment in an SNP that enrolls only special needs individuals an individual must meet the eligibility requirements for the specific SNP.

Before processing an enrollment into an exclusive dual eligible SNP, the SNP must confirm eligibility, including both MA eligibility and Medicaid eligibility. Disproportionate share dual eligible SNPs must verify Medicaid eligibility only for applicants who are enrolling on the basis of their Medicaid eligibility. Acceptable proof of Medicaid eligibility can be a current Medicaid card, a letter from the state agency that confirms entitlement to Medical Assistance, or verification through a systems query to a State eligibility data system. The aforementioned documents or State systems verifications are acceptable proof of Medicaid entitlement for beneficiaries residing in the 50 states and the District of Columbia. An individual's current eligibility for the Medicare Part D Low Income Subsidy (LIS) or any other Medicaid status flag in CMS systems are **not acceptable** for initial or ongoing Medicaid eligibility verification for the purposes of determining dual eligible SNP eligibility. For current enrollees, the SNP must verify continuing eligibility (e.g. full or partial dual status, as applicable) at least as often as the state Medicaid agency conducts re-determinations of Medicaid eligibility.

For enrollments into an institutional SNP, the organization must confirm that the individual requires an institutional (skilled nursing facility (SNF), nursing facility (NF),

SNF/NF, intermediate care facility for the mentally retarded (ICF/MR) or inpatient psychiatric facility) level-of-care, and that the need for an institutional level-of-care has lasted 90 days or longer. When an institutional SNP opts to enroll special needs individuals prior to a 90-day length-of-stay, the needs-assessment (pre-approved by CMS) must show that the individual's condition makes it likely that the length-of-stay (or need for an institutional level-of-care) will be at least 90-days. When the institutional SNP limits enrollment to individuals in a facility, it must confirm residence in the facility.

For enrollments into a chronic condition SNP, the organization must contact the provider or provider's office to confirm that the individual has the qualifying condition. The organization must obtain this information in one of the following two ways:

1) *Contact the provider or provider's office and obtain verification of the condition prior to enrollment, or*

2) *Utilize a CMS-approved pre-enrollment qualification assessment tool prior to enrollment and obtain verification of the condition from the provider or provider's office on a post-enrollment basis.*

For either method, verification from the provider can be in the form of a note from a provider or the provider's office, or documented telephone contact with the provider or provider's office confirming that the individual has the condition. The organization may need to obtain written permission (separately from the enrollment form) permitting it to contact the beneficiary's provider's office to obtain verification of the condition.

If the organization chooses to use a CMS-approved prequalification assessment tool, it has until the end of the first month of enrollment to confirm that the enrollee has the qualifying condition necessary for enrollment into the severe/chronic disabling condition SNP. If it cannot confirm that the enrollee has the qualifying condition within that time, the organization has the first seven calendar days of the following month (i.e, the second month of enrollment) in which to send the beneficiary notice of his/her disenrollment for not having the qualifying condition. Disenrollment is effective at the end of the second month of enrollment. The beneficiary has an SEP that begins with the month of notification and continues through the two following months to enroll in another MA organization for a prospective effective date. This SEP allows a beneficiary time to find a new plan while reducing the potential for incurring a late enrollment penalty.

> *EXAMPLE: A beneficiary submits a request to enroll in a SNP effective March 1st. The SNP uses a CMS-approved prequalification assessment tool in February and attempts to confirm the beneficiary's special needs status but is unable to do so by March 31st. Between April 1st and April 7th (inclusive), the SNP must send a notice of prospective disenrollment to the beneficiary indicating April 30th as the disenrollment date. If the beneficiary fails to select a new plan by April 30th, his/her SEP will continue through June 30th. S/he can enroll in a plan effective June 1st or July 1st.*

30 - Election Periods and Effective Dates

42 CFR 422.62 & 422.68

In order for an MA organization to accept an *enrollment* request, a valid request must be made during an election period (see §10 for the definition of "election"). It is the responsibility of the organization to determine the election period of each *enrollment* request. There are f*our* types of election periods during which individuals may make *enrollment request*s. They are:

- The Annual Election Period (AEP);
- The Initial Coverage Election Period (ICEP);
- All Special Election Periods (SEP); *and*
- The Open Enrollment Period (OEP)

Unless a CMS-approved capacity limit applies, all MA organizations must accept *requests to enroll* in their MA plans (with the exception of Medicare MSA plans) during the AEP, an ICEP, and any SEP that allows enrollment into the specific plan. (Refer to §30.7 for election periods for Medicare MSA plans.) When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until the limit is lifted. Refer to §30.8 and §30.8.1 for more information on OEP plan closures, capacity limits and reserved vacancies.

30.1 - Annual Election Period (AEP)

During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. The last *enrollment request* made, determined by the application date, will be the *enrollment request* that takes effect (refer to §60.1 for information on multiple transactions).

The AEP occurs November 15 through December 31 of every year. *The AEP is also referred to as the "Fall Open Enrollment" season in Medicare beneficiary publications and other tools.*

Note: An employer/union sponsored MA plan may have an "open season" as determined by the employer. This may or may not correspond with the MA annual election period Therefore, orgs are not required to accept enrollment requests into empl*oyer*/union plans during the AEP (unless the AEP and open season occur simultaneously); however, organizations must accept valid requests for disenrollment.

30.2 - Initial Coverage Election Period (ICEP)

The ICEP is the period during which an individual newly eligible for MA may make an initial *enrollment request* to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to **both** Medicare Part A and Part B and ends on the later of:

1. The last day of the month preceding entitlement to both Part A and Part B, or;

2. The last day of the individual's Part B initial enrollment period.

The initial enrollment period for Part B is the seven (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 additional information.

Once an ICEP *enrollment request* is made and enrollment takes effect, the ICEP election has been used.

EXAMPLES

- Mrs. *Donovan*'s 65th birthday is *June* 20, 2006. She is eligible for Medicare Part A and Part B beginning *June* 1, 2006 and has decided to enroll in Part B beginning on *June* 1. Her ICEP begins on *March* 1, 2006 and ends on *September* 3*0*, 2006.

- Mrs. Smith's 65th birthday is April 20, 2006. She is eligible for Medicare Part A and Part B beginning April 1, 2006. Because she is still working and has health insurance provided by her employer, she has decided not to enroll in Part B during her initial enrollment period for Part B. Upon retiring, she will have the opportunity to enroll in Part B (through a Part B SEP). She has enrolled in Part B effective May 1, 2007. Her ICEP would be February 1 through April 30, 2007.

Please note that the ICEP for an MA enrollment election will frequently relate to either the individual's 65th birthday or the 25th month of disability, but it must **always** relate to the individual's entitlement to **both** Medicare Part A and Part B. When an individual enrolls in an MA-PD plan, s/he has used both the ICEP and the IEP for Part D (see §30.2.1).

30.2.1 - Initial Enrollment Period for Part D (IEP for Part D)

The Initial Enrollment Period for Part D (IEP for Part D) 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 he or she is entitled to Part A OR is enrolled in Part B, AND permanently resides in the service area of a Part D plan. *Ultimately, CMS provides a part D eligibility effective date and maintains it in CMS systems.*

At the beginning of the Medicare prescription drug coverage program, all current Part D eligible individuals had an IEP for Part D that began on November 15, 2005, and ended on May 15, 2006. During the IEP for Part D, individuals may make one Part D enrollment choice, including enrollment in an MA-PD plan.

Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B. The initial enrollment period for Part B is the seven (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 additional information.

Individuals not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B have an IEP for Part D that is the 3 months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility for 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.

The ICEP and the IEP for Part D occur together as one period when a newly Medicare eligible individual has enrolled in BOTH Part A and B at first eligibility. Should an individual delay enrollment in Part B to a later time, the ICEP and IEP become separate with the ICEP changing to then occur as the 3 months immediately preceding entitlement to BOTH parts A and B.

If a Medicare entitlement determination is made retroactively *eligibility for Part D begins with the month in which the individual received notification of the retroactive entitlement decision. Therefore,* the *Part D* 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 organization receives a completed enrollment request.

In MA context, the IEP for Part D applies only to MA-PD enrollment *request*s. Accordingly, when an applicant has both the ICEP and IEP available to him/her, the organization must submit the transaction to CMS as an IEP election.

30.3 - Open Enrollment Period (OEP)

In addition to their opportunities during the AEP, SEP, or ICEP, MA eligible individuals may make **one** MA OEP *enrollment request* from January 1st through March 31st. MA organizations are not required to open their MA plans for enrollment during an OEP. However, MA organizations must accept valid requests for disenrollment from MA-only plans during the OEP since Original Medicare is always open during an OEP. In addition, if an MA organization has more than one MA plan, the MA organization is not required to open each plan for enrollment during the same time frames.

If an MA organization opens a plan during part of an OEP, it is not required to open the plan for the entire month – it may choose to open the plan for only part of the month.

The OEP (also including the OEP NEW *and* OEPI described below) is not available for Medicare MSA *enrollment request*s. Please refer to §30.7 for more information on Medicare MSA *enrollment request*s.

OEP Limitation:

OEP (including OEPNEW but not including OEPI) *enrollment requests* must be made to *enroll in* the same type of plan (regarding Medicare prescription drug coverage) in which the individual is already enrolled, as follows:

(1) An individual who is enrolled in an MA-PD plan may elect another MA-PD plan or disenroll from the MA-PD by enrolling in a *Part D plan* (there is a corresponding SEP to permit this Part D enrollment). To effectuate this *enrollment request*, the individual must elect an MA-PD plan or enroll in a *Part D plan*. Either action will generate an automatic disenrollment from the current MA-PD plan. An individual enrolled in a *Part D plan* may elect an MA-PD.

Such individual may elect an MA-*only PFFS or MSA* plan *only if he or she obtains Part D coverage as well*. MA organizations must deny OEP requests for voluntary disenrollment from an MA-PD plan.

(2) An individual who is enrolled in an MA plan and who does not have Part D coverage may elect another MA plan that does not include Part D coverage or may elect to disenroll from the MA plan.

An individual enrolled in Original Medicare (or a non-MA Medicare health plan, such as a cost plan) but not in a PDP may elect an MA plan that does not include Part D coverage. Individuals who do not have Part D coverage, regardless of whether they have other creditable coverage, may not elect an MA-PD plan during this period.

The table below describes possible MA-OEP *enrollment request* options:

If current coverage is	**Can use OEP to get**	**Cannot use OEP to get**
Medicare Advantage with prescription drug coverage (MA-PD)	A different MA-PD or Original Medicare + PDP or MA-*only* PFFS + PDP	MA-only or Original Medicare only (cannot drop drug coverage)
Medicare Advantage with no prescription drug coverage (MA-only)	A different MA-only or Original Medicare only	MA-PD or Original Medicare + PDP (cannot add drug coverage)
MA-only PFFS + PDP	MA-PD or different MA-only PFFS and same PDP or Original Medicare and same PDP	MA-only or Original Medicare only (cannot drop drug coverage)
Original Medicare and a prescription drug plan (PDP)	MA-PD or MA-PFFS and the same PDP.	MA-only or A different PDP to use with Original Medicare (cannot drop drug coverage)
Original Medicare only	MA-only	MAPD or Original Medicare + PDP (cannot add drug coverage)

MSA	*N/A*	*The MA OEP does not apply to enroll into or disenrollment from an MSA plan.*

NOTE: An OEP enrollment *request* into another MA plan that results in an automatic disenrollment from a current plan will count as *one* OEP *enrollment request*.

30.3.1 - Open Enrollment for Newly Eligible Individuals (OEPNEW)

An individual who becomes MA eligible may make **one** MA OEPNEW election during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the 3rd month of entitlement, or on December 31st of the same year, whichever occurs first, subject to the limitations described in §30.3 above.

An OEPNEW election is separate from an OEP election. An MA organization is not required to accept *requests to enroll* into its plan during the OEPNEW, but if it is open for these *enrollment requests*, it must accept all OEPNEW *requests to enroll* into the plan.

30.3.2 - Open Enrollment Period for Institutionalized Individuals (OEPI)

The OEPI is continuous for institutionalized individuals. For purposes of enrollment under the OEPI election period, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution, as defined in §10. The *OEPI* ends two months after the month the individual moves out of the institution.

Special Note for SNP enrollment:

In addition, the OEPI is available for individuals who meet the definition of "institutionalized" to enroll in or disenroll from an MA SNP for institutionalized individuals.

An MA eligible institutionalized individual can make an unlimited number of MA *enrollment request*s during the OEPI. In addition, the "OEP limitation" described in §30.3 does not apply to OEPI *enrollment request*s. An MA organization is not required to accept *requests to enroll* into its plan during the OEPI, but if it is open for these *enrollment requests*, it must accept all OEPI *requests to enroll* into the plan.

Since the OEPI is continuous *for institutionalized individuals*, Original Medicare is *also* open continuously for institutionalized individuals. Therefore, MA organizations must accept requests for disenrollment from their MA plans during the OEPI, since Original Medicare is open continuously for institutionalized individuals.

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.

30.4 - Special Election Period (SEP)

Special election periods constitute periods outside of the usual IEP, AEP or OEP when an individual may elect a plan or change his or her current plan election. As detailed below, there are various types of SEPs, including SEPs for dual eligibles, and for individuals whose current plan terminates, who change residence and who meet "exceptional conditions" as CMS may provide, consistent with §1851(e)(4) of the Act and §422.62(b) of the MA regulations.

Depending on the nature of the particular special election period, an individual may:

- *Discontinue an enrollment in an MA plan and enroll in Original Medicare*
- *Switch from Original Medicare to an MA plan*
- *Switch from one MA plan to another MA plan*

Certain SEPs are limited to an enrollment or disenrollment *request*. If the individual disenrolls from (or is disenrolled from) the MA plan and changes to Original Medicare, the individual may subsequently elect a new MA plan within the SEP time period. Once the individual has elected the new MA plan, the SEP ends for that individual even if the time frame for the SEP is still in effect. In other words, **the SEP for the individual ends when the individual elects a new MA plan or when the SEP time frame ends, whichever comes first, unless specified otherwise within an SEP.**

Note: An individual's eligibility for an SEP does not convey eligibility to enroll in the plan; an individual must also meet all applicable MA eligibility criteria.

It is *generally* the responsibility of the organization to determine whether the individual is eligible for an SEP. *The exception to this determination requirement would be enrollment requests completed or approved by CMS staff.* To make this determination, the organization may need to contact the individual *directly or request this information as part of the enrollment request by incorporating specific statements regarding SEP eligibility (see Exhibit 1a)*. Unless otherwise required in this guidance, the organization MUST accept verbal *or written* confirmation from the individual regarding the conditions that make him or her eligible for the SEP. *Organizations that obtain this information on the enrollment request are not required to obtain an additional verbal or written confirmation of SEP eligibility.*

For enrollment requests obtained during a face-to-face interview or telephone request, the determination of SEP eligibility can be made at that time. For enrollment requests made using paper, or via the internet or the Medicare OEC (without accompanying CMS approval), the organization is not required to contact the applicant to confirm SEP eligibility if the enrollment request includes the applicant's attestation of SEP eligibility.

If SEP eligibility is obtained orally (by phone), the organization must document this contact and retain this information with the enrollment record. If the organization obtains this confirmation through a written notice, such notice must afford the beneficiary the option of calling the organization and confirming this information verbally. The organization must obtain this confirmation in accordance with §40.2.2. If the organization is not able to obtain SEP eligibility information from the applicant, the

organization must deny the enrollment request and provide the individual a notice of denial of enrollment (see Exhibit 7).

The following 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 (EGHP)	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 have or want to obtain VA benefits?
Full and Partial Dual Eligible	Do you currently have Medicaid coverage? Did you recently receive a yellow letter from CMS? Does your state pay for your Medicare premiums? Have you recently lost coverage under Medicaid?
Other Low Income Subsidy	Have you recently been approved for extra help? Have you recently received a green letter from CMS? Do you receive SSI cash benefits without Medicaid? Did you receive a letter from Medicare letting you know that you automatically qualify for extra help?
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?
Retroactive notice of Medicare entitlement	Have you recently received a notice telling you that you have been approved for

	Medicare for a “retroactive” date? If so, when did you receive this notice?
PACE	For enrollment – are you currently enrolled in a special plan called “PACE”?

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 coverage. For example, if an SEP exists for an individual from May - July, then an MA organization must receive an *enrollment request* from that individual some time between May 1 and July 31 in order to consider the *enrollment request* an SEP *enrollment request*. However, the type of SEP will dictate what the effective date of coverage may be, and that effective date of coverage may be some time after July 31. The following discussion of SEPs and their corresponding effective dates will demonstrate this concept more fully.

Individuals who disenroll from an MA plan to Original Medicare during an SEP are provided Medigap guaranteed issue rights. These rights are not afforded to those individuals who enroll into an MA plan during an SEP. MA organizations are required to notify members of these guaranteed issue rights when members disenroll to Original Medicare during a SEP. See §§50.1.7 and 50.2 for the additional information regarding these notification requirements

The time frames and effective dates for SEPs are discussed in the following sections. SEPs apply to local, regional and MA-PD plans unless otherwise specifically stated. Corresponding SEPs for enrollment in Prescription Drug Plans (PDPs) are provided in separate PDP Enrollment guidance.

30.4.1 - SEPs for Changes in Residence

An SEP for a change in residence exists for these scenarios:

1) individuals who are no longer eligible to be enrolled in an MA plan due to a change in permanent residence outside of the MA plan service area;

2) individuals who will have new Medicare health or Part D plans available to them as a result of a permanent move.

The SEP may begin with either the 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 MA organization that he/she is permanently moving.

When the individual notifies the organization of a permanent move out of the plan service area, the SEP may begin either the month before the individual’s permanent move, if the individual notifies the organization in advance, or the month the individual provides the notice of the move, if the individual has already moved. The SEP continues for two months following the month it begins or the month of the move, whichever is later.

If the organization learns from CMS or another source (as described in §50.2.1.3) that the individual has been out of the service area for over six months and the organization has not been able to confirm otherwise with the individual, the SEP starts at the beginning of the sixth month and continues through to the end of the eighth month.

For enrollments associated with permanent moves, the enrollment effective date is determined by the **date the MA organization receives the enrollment request**. The individual may choose an effective date of up to three months after the month in which the MA organization 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 MA organization receives the enrollment request.

EXAMPLE 1

- A beneficiary is a member of an MA plan in Florida and intends to move to Arizona on June 18. A SEP exists for this beneficiary from May 1 - August 31.

  A. If an MA organization in Arizona receives an enrollment *request* from the beneficiary in May, the beneficiary can choose an effective date of July 1, August 1, or September 1.

  B. If the MA organization receives the enrollment *request* 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 MA organization receives the enrollment *request* in July, the beneficiary could 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 an MA plan. 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 makes the *enrollment request* into an MA plan, the individual must provide the specific address where the individual will permanently reside upon moving into the service area, so that the MA organization can determine that the individual meets the residency requirements for enrollment in the plan.

Disenrollment from Previous MA Plan

Please keep in mind that a member of an MA plan who moves permanently out of the service area must be disenrolled from the plan, unless continuation of enrollment applies. A member of an MA plan who is 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 MA plan, given the fact that the individual will no longer be enrolled in the original MA plan after the month of the move or after the sixth month (whichever is appropriate). Unless an individual enrolls in a new MA plan with an effective date of the month after

the move or the beginning of the seventh month (e.g., the individual moves on June 18 and enrolls in a new plan effective July 1), he/she will be enrolled in Original Medicare until he/she elects the new MA plan.

30.4.2 - SEPs for Contract Violation

In the event an individual is able to demonstrate to CMS that the MA organization offering the MA plan of which he/she is a member substantially violated a material provision of its contract under MA in relation to the individual, or the MA organization (or its agent) materially misrepresented the plan when marketing the plan, the individual may disenroll from the MA plan and elect Original Medicare or another MA plan. The SEP will begin once CMS determines that a violation has occurred. Its length will depend on whether the individual immediately elects a new MA plan upon disenrollment from the original MA plan or whether the individual initially elects Original Medicare before choosing a new MA plan.

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:

- A SEP exists such that an individual may elect another MA plan or Original Medicare during the last month of enrollment in the MA organization, for an effective date of the month after the month the new MA organization receives the enrollment *request*.

  EXAMPLE

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

- If the individual in the above example elected Original Medicare during the last month of enrollment in the MA organization (either by choosing Original Medicare or by not choosing an MA plan and therefore defaulting to Original Medicare), the individual will be given an additional 90 calendar days from the effective date of the disenrollment from the MA organization to elect another MA plan. During this 90-day period, and until the individual elects a new MA plan, the individual will be enrolled in Original Medicare. The individual may choose an effective date into a new MA plan beginning any of the three months after the month in which the MA organization receives the enrollment *request*. However, the effective date may not be earlier than the date the MA organization receives the enrollment *request*.

  EXAMPLE

  On January 16, CMS determines, based on a member's allegations that the MA organization substantially violated a material provision of its contract. The member decides to return to Original Medicare. As a result, the member is

disenrolled from the MA plan on January 31 and enrolled in Original Medicare with a February 1 effective date. A 90-day SEP continues to exist for the beneficiary from February 1 through April 30. In this example, a new MA organization then receives an enrollment *request* from the individual on April 15. The beneficiary can 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 elect another plan on a case-by-case basis. Depending on the circumstances surrounding the contract violation, CMS may determine a retroactive enrollment into another MA plan is warranted.

30.4.3 - SEPs for Non-renewals or Terminations

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

In particular:

- **Non-renewals -** A SEP exists for members of MA plans that will be affected by *plan or* contract non-renewals that are effective January 1 of the contract year (42 CFR §422.506). For this type of non-renewal, MA organizations are required to give notice to affected members at least 90 calendar days prior to the date of non-renewal (42 CFR §422.506(a)(2)(ii)). To help coordinate with the notification time frames, the SEP begins October 1 and ends on *January* 31 of *the following* year.

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

- **MA organization Termination of Contract and Terminations/Contract Modifications by Mutual Consent -** A SEP exists for members of plans who will be affected by a termination of contract by the MA organization or a modification or termination of the contract by mutual consent (42 CFR §§422.512 and 422.508(a)(1)). For this type of termination, MA organizations are required to give notice to affected members at least 60 calendar days prior to the proposed date of termination (§422.512(b)(2)). To help 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 elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare 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 elect an MA plan (for a current, 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 MA organization receives the enrollment *request*.

EXAMPLE

If an MA organization 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; however, the effective date may not be earlier than the date the new MA organization receives the enrollment *request*.

- **CMS Termination of MA organization Contract -** A SEP exists for members of plans that will be affected by MA organization contract terminations by CMS (42 CFR 422.510). For this type of termination, MA organizations are required to give notice to affected members at least 30 calendar days prior to the effective date of the termination (422.510(b)(1)(ii)). To help 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 elect an MA plan before the termination effective date, he/she will be defaulted to Original Medicare 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 elect an MA plan (for a current, not retroactive, effective date).

  Beneficiaries affected by these types of terminations may select 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 MA organization receives the *enrollment request*.

  EXAMPLE

  If CMS terminates an MA organization 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 MA organization receives the *enrollment request*.

- **Immediate Terminations By CMS -** CMS will establish the SEP during the termination process for immediate terminations by CMS (§422.510(b)(2)), where CMS provides notice of termination to an MA plan's members and the termination may be mid-month.

30.4.4 - 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. The SEPs CMS has established include:

1. SEP EGHP (Employer/Union Group Health Plan) - An SEP exists for individuals making MA *enrollment request*s into or out of employer sponsored MA plans*,* for individuals to disenroll from an MA plan to take employer sponsored coverage of any kind*,* and for individuals disenrolling from employer sponsored coverage (including COBRA coverage) to elect an MA plan. The SEP EGHP may be used when the EGHP allows the individual to make changes in their health coverage choices, 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 sponsored plan and ends 2 months after the month the employer or union coverage ends.

The individual may choose an effective date of up to three months after the month in which the individual completed an enrollment or disenrollment request*, h*owever, the effective date may not be earlier than the first of the month following the month in which the request was made.

NOTE: If necessary, the MA organization may process the *enrollment request* with a retroactive effective date, as outlined in §60.6. Keep in mind that all MA eligible individuals, including those in EGHPs, may elect MA plans during the AEP and ICEP, during any other SEP, and during the OEP if the plan is open for enrollment. The SEP EGHP does not eliminate the right of these individuals to make *enrollment request*s during these time frames.

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 an MA organization, 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, are 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 of the Act cost contracts for the area in which the enrollee lives.

This SEP is available only to Medicare beneficiaries who are enrolled with an HMO or CMP under a §1876 of the Act cost contract that will no longer be offered in the area in which the beneficiary lives. Beneficiaries electing to enroll in an MA plan via this SEP must meet MA eligibility requirements.

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

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

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

5. 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 Part B and receive any type of assistance from the Title XIX (Medicaid) program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (e.g. QMB-only, SLMB-only, 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, an MA plan. The effective date of an *enrollment request* made using this SEP would be the first of the month following receipt of an enrollment request. However, as described in §*40.1.5*, the effective date for auto-enrollments of full-benefit dual-eligible individuals may be retroactive.

In addition, MA-eligible individuals who are no longer eligible for Title XIX benefits have an SEP beginning the month they lose eligibility plus two additional months to make an enrollment choice in another MA plan.

6. 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" - For Medicare beneficiaries who dropped a Medigap policy when they enrolled for the first time in an MA plan, §1882(s)(3)(B)(v) of the Act provides 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. Such individuals would not be eligible for the special election period provided for in the last sentence of §1851(e) of the Act, because they did not enroll in an MA plan immediately upon becoming Medicare eligible, but instead had been in the Original Medicare Plan for some period of time. The right to "guaranteed issue" of a Medigap policy under §1882(s)(3)(B)(v) of the Act would be meaningless if individuals covered by this provision could not disenroll from the MA plan while they were still in a trial period.

Accordingly, there is an SEP for individuals who are eligible for "guaranteed issue" of a Medigap policy under §1882(s)(3)(B)(v) of the Act upon disenrollment from the MA plan in which they are enrolled. This SEP allows a qualified individual to make a one-time election to disenroll from their first MA plan to join the Original Medicare Plan at any time of the year. The SEP begins the month the individual disenrolls from the MA-PD plan and continues for two additional months. The effective date would be dependent upon the situation.

7. SEP for Individuals with ESRD Whose Entitlement Determination Made Retroactively - If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to prospectively elect an MA plan offered by the MA organization, provided:

a. They were in a health plan offered by the same MA organization the month before their entitlement to Parts A and B;

b. Developed ESRD while a member of that health plan; and

c. Are still enrolled in that health plan.

This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his/her entitlement date adjusted to begin at the time of dialysis, rather than the customary 3-month period AFTER dialysis begins.

The SEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for 2 additional months after the month the notice is received. The *enrollment request* may only be made prospectively and the effective date is the first day of the month after the MA plan receives the *enrollment request*.

8. SEP for Individuals Whose Medicare Entitlement Determination Made Retroactively - If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect an MA plan during his/her ICEP. Therefore, these individuals will be allowed to elect an MA plan offered by the MA organization. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely.

The SEP begins the month the individual receives the notice of the Medicare entitlement determination and continues for two additional months after the month the notice is received. The effective date depends on the situation but is not earlier than the first day of the month in which the notice of the Medicare entitlement determination is received by the individual.

9. *MA* SEPs *to Coordinate With Part D Enrollment Periods* – Individuals eligible for an *enrollment period* under the guidance for Part D enrollment and disenrollment may use that SEP to make an election into or out of an MA-PD plan (as applicable). Most Part D SEPs are duplicated in the MA program as described above*; however, t*hose that are not *described elsewhere* are provided here:

A. Involuntary loss of creditable 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 a failure to pay premiums. The SEP permits enrollment into a Part D plan and begins with the month in which the individual is advised of the loss of creditable coverage and ends two months after either the loss (or reduction) occurs or the individual received 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 3 months prospective.

B. Individuals who are not adequately informed of a loss of creditable coverage, or that they never had creditable coverage, have an SEP to enroll in a Part D plan. The SEP permits one enrollment in, or disenrollment from, a Part D plan on a case-by-case basis. This SEP begins the month of CMS approval of this SEP and continues for two additional months following this approval.

C. Individuals whose enrollment or non-enrollment in a Part D plan is erroneous due to an action, inaction or error by a Federal Employee. The SEP permits disenrollment and/or enrollment in a Part D plan on a case-by-case basis. Requests for this SEP must be developed and presented to the CMS Regional

Office serving the MA-PD plan for which the SEP will apply. This SEP begins the month of CMS approval of this SEP and continues for two additional months following this approval.

D. 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 *request* or on the last day of the second month following the month cost plan membership ended, whichever is earlier.

E. *An individual eligible for an additional Part D IEP, such as an individual currently entitled to Medicare due to a disability and who is attaining age 65, has an MA SEP to coordinate with the additional Part D IEP. The SEP may be used to disenroll from an MA-only or MA-PD plan to Original Medicare, or to enroll in an MA-only plan (regardless of whether the individual uses the Part D IEP to enroll in a PDP). The SEP begins and ends concurrently with the additional Part D IEP.*

For more information about PDP enrollment and disenrollment, please refer to the CMS guidance for PDPs.

10. SEP for Individuals Who Lose Special Needs Status - CMS will provide an SEP for individuals enrolled in a SNP who are no longer eligible for the SNP because they no longer meet the specific special needs status. This SEP begins the month the individual's special needs status changes and ends the earlier of when the beneficiary makes an *enrollment request* or three months after the expiration of the period of deemed continued eligibility.

11. SEP for Individuals who belong to a Qualified SPAP *or who lose SPAP eligibility* – Individuals who belong to a qualified SPAP are eligible for an SEP to make one enrollment *request* 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. In summary, a beneficiary may use this SEP to switch from an MA-PD plan to another PDP or MA-PD plan, from Original Medicare without a PDP to Original Medicare with a PDP or to an MA-PD plan, from a PDP to another PDP or MA-PD plan or from an MA-only plan (no prescription drug coverage) to a PDP or MA-PD plan. *In addition, individuals no longer eligible for SPAP benefits will have an SEP beginning with the month they lose eligibility plus two additional months to make an enrollment choice in another PDP or MA-PD.*

12. 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. *The effective date for all enrollments under this SEP will be prospective, effective the first day of the month following the organization's receipt of the enrollment request.*

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 or an MA-PD plan and submits a request in November. He does so using this SEP and his enrollment is effective December 1st.*

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 redeeming process will have an SEP that begins the month they are notified and continues for two months.

13. SEP for Enrollment into a Chronic Care SNP *and for Individuals found ineligible for 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. *In addition, individuals enrolled in a Chronic Care SNP who have a severe/disabling chronic condition which is not a focus of their current SNP are eligible for this SEP. Such individuals have an opportunity to enroll in a Chronic Care SNP that focuses on this other condition. Eligibility for this SEP ends at the time the individual enrolls in the new SNP.*

Individuals who are found after enrollment not to have the qualifying condition necessary to enroll in a Chronic Care SNP will have an SEP to enroll in a different MA-PD plan or an MA-only plan with accompanying Part D coverage. This would normally occur when the required post enrollment verification with a provider did not confirm the information provided on the pre-enrollment assessment tool. This SEP begins when the plan notifies the individual of the lack of eligibility and extends through the end of that month as well as the following two months. The SEP ends when the individual makes an enrollment election or on the last day of the second of the two months following notification. Any enrollments made during this election period are for prospective effective dates.

14. 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 or 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. Additionally, individuals enrolled in an MA-PD plan who have or are enrolling in other creditable coverage may use this SEP to disenroll from the MA-PD plan by enrolling in an MA-only plan.

30.4.5 - SEPs for Beneficiaries Age 65 (SEP65)

MA eligible individuals who elect an MA plan *(other than an MSA plan)* during the initial enrollment period (IEP) for Part B surrounding their 65th birthday have an SEP. This "SEP65" allows the individual to disenroll from *such an* 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.

The IEP is established by Medicare and begins 3 months before and ends 3 months after the month of the individual's 65th birthday.

30.5 - Effective Date of Coverage

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their effective date. Furthermore, except for EGHP *enrollment request*s, the effective date is generally not prior to the receipt of an *enrollment request* by the MA organization. An enrollment cannot be effective prior to the date the beneficiary or his/her legal representative signed the enrollment form or submitted the enrollment *request*. §40.2 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 MA organization must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the enrollment *request* is received by the MA organization.

Once the election period is identified by the MA organization, the MA organization must determine the effective date. Refer to §60.8 to determine the effective date for a continuation of enrollment. In addition, EGHP enrollments may be retroactive (refer to §60.6 for more information on EGHP retroactive effective dates).

Effective dates are as follows:

Election Period	**Effective Date of Coverage**	**Do MA organizations have to accept enrollment *request*s in this election period?**
Initial Coverage Election Period and Initial Enrollment Period for Part D	First day of the month of entitlement to Medicare Part A and Part B – or- The first of the month following the month the *enrollment request* was made if after entitlement has occurred.	Yes – unless capacity limit applies (see §30.8 for capacity limit information). IEP for Part D is applicable only to MA-PD enrollment *request*s.
Open Enrollment Periods (OEP, OEPNEW, OEPI)	First day of the month after the month the MA organization receives an enrollment *request*	No - the MA organization can choose to be "open" or "closed" for enrollments during these periods.
Annual Election Period	January 1 of the following year	Yes – unless capacity limit applies
Special Election Period	Varies, as outlined in §30.4	Yes – unless capacity limit applies

It is possible for an individual to make an enrollment *request* when more than one election period applies, and therefore it is possible that more than one effective date could be used. Therefore, if an individual makes an enrollment *request* when more than one election period applies, an MA organization must allow the individual to choose the election period (and therefore the effective date) in which he/she is enrolling (see exception in the next paragraph regarding the ICEP).

If the individual's ICEP and another election period overlap, the individual may not choose an effective date any earlier than the month of entitlement to Medicare Part A and Part B.

EXAMPLE

> If an individual will be entitled to Medicare Part A and Part B in February his ICEP is November through May. If an MA organization receives an enrollment *request* from that individual during the AEP, the individual may NOT choose a January 1 effective date for the AEP and must be given a February 1 effective date for the ICEP because January 1st is earlier than the month of entitlement to Medicare Part A and Part B.

If an individual makes an enrollment *request* when more than one election period applies but does not indicate or select an effective date, then the MA organization should assign an effective date that benefits the individual and should attempt to contact the individual to determine the individual's preference. If unsuccessful, the MA organization must use the following ranking of election periods. The election period with the highest rank generally determines the effective date of enrollment (refer to §30.6 for procedures to determine the effective date of voluntary disenrollment).

Ranking of Election Periods: (1 = Highest, 4 = Lowest)

1. ICEP/IEP-D
2. SEP
3. AEP
4. OEP / OEPNEW / OEPI

30.5.1 - Effective Date of Auto- and Facilitated Enrollments

The effective dates for auto-enrollment and facilitated enrollment are described in §*40.1.5* of this chapter.

30.6 - Effective Date of Voluntary Disenrollment

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not select their effective date of disenrollment. §50.1 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.

When a member disenrolls through the MA organization or 1-800-MEDICARE, the *enrollment request* will return the member to Original Medicare. If a member elects a new MA plan while still a member of a different plan, he/she will automatically be disenrolled from the old plan and enrolled in the new plan by CMS systems with no duplication or delay in coverage.

As with enrollments, it is possible for a member to make a disenrollment request when more than one election period applies. Therefore, in order to determine the proper effective date, the MA organization **must** determine which election period applies to each member **before** the disenrollment may be transmitted to CMS.

If an MA organization receives a disenrollment request when more than one election period applies, the MA organization must allow the member to choose the effective date of disenrollment. If the member does not make a choice of effective date, then the MA organization must give the effective date that results in the **earliest** disenrollment.

Effective dates for voluntary disenrollment are as follows (refer to §§50.2 and 50.3 for effective dates for involuntary disenrollment).

Election Period	**Effective Date of Disenrollment***	**Do MA organizations have to accept *enrollment request*s in this election period?**
Open Enrollment Periods	First day of the month after the month the MA organization receives a disenrollment request.	MA-only plans *(except for MSA)* must accept requests for voluntary disenrollment because Original Medicare is always open during this election period. MA-PD plans must deny such requests. Refer to §30.3 for information on OEP limitations.
Annual Election Period	January 1 of the following year.	Yes
Special Election Period	Varies, as outlined in §30.4	Yes

***NOTE:** *CMS* may allow up to 90 days retroactive payment adjustments for EGHP disenrollments. Refer to §60.6 for more information.

30.7 - Election Periods and Effective Dates for Medicare MSA Plans

Individuals may only enroll in Medicare MSA plans (should one be offered in their area) during the ICEP or the AEP; they may not enroll in Medicare MSA plans during the OEP or a SEP (see exception below). The effective date of coverage is determined by the election period in which an *enrollment request* is made. Effective dates are provided in §30.5 of this chapter.

Individuals may only disenroll from Medicare MSA plans during the AEP or an SEP. The effective date of disenrollment during an SEP depends on the type of SEP.

Additionally, MSA enrollees may not use the MA OEP to elect another MA plan type as doing so would require disenrollment from the MSA, which is not permitted during the MA OEP.

Exception: To facilitate the offering of employer/union sponsored MSA plans, CMS will permit individuals to request enrollment into an employer/union sponsored MSA plan using the Employer Group Health Plan Special Enrollment Period (EGHP SEP).

30.8 - Closed Plans, Capacity Limits, and Reserved Vacancies

An MA organization may specify a capacity limit for one or all of the MA plans it offers and reserve spaces for individual and employer or union group commercial members who are converting from a commercial product to an MA product at the time the member becomes eligible (i.e., conversion enrollments). When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until space becomes available.

All MA plans (with the exception of Medicare MSA plans; see §30.7) must accept *enrollment request*s made during the AEP, ICEP and SEP unless an approved capacity limit applies. Only with an approved number of reserved vacancies may an MA organization set aside openings for the enrollment of conversions (i.e., ICEP *enrollment request*s).

Unlike the mandatory election periods (AEP, ICEP and SEP), an MA organization has the option to be open for *enrollment request*s made during the OEP. An MA organization may voluntarily close one or more of its MA plans during any portion of the OEP. If an MA plan is closed for OEP enrollment, then it is closed to all individuals in the entire plan service area who are making OEP *enrollment request*s. All MA plans must accept OEP disenrollment *request*s, subject to the OEP limitation described in §30.3, whether or not it is open for enrollment.

NOTE: For purposes of auto-enrollment and facilitated enrollment, MA organizations must ensure that the MA-PD plans into which beneficiaries are deemed to have enrolled have the capacity to accept them. Should a capacity limit be proposed for an MA-PD plan, it must be set high enough to ensure all beneficiaries may be transitioned.

30.8.1 - MA Plan Closures

The decision to be open or closed for OEP enrollment *request*s rests with the MA organization and does not require CMS approval. However, if an MA organization has an MA plan that is open during an OEP, and decides to change this process, it must notify CMS and the general public 30 calendar days in advance of the new limitations on the open enrollment process.

If an MA organization has more than one MA plan, those plans may be open or closed independent of one another, as the MA organization determines. Further, each MA plan may be open for all or only part of the OEP. For example, an MA plan may be open:

1. Only some months of the OEP (such as only during March);

2. Some portion of certain months; and/or

3. During the first 25 days (or any part) of each month.

When an MA plan is voluntarily closed for the OEP, it is closed to **ALL** OEP enrollment *request*s, but must still accept *enrollment request*s made during the ICEP and SEP as well as be open for the AEP, unless an approved capacity limit applies and has been reached (excluding reserved vacancies). The CMS may approve a partial service area closure for capacity reasons. If a plan is closed in a portion of its service area for capacity reasons, that plan may be open during the OEP in the remaining portion of the service area.

When an MA plan is closed due to an approved capacity limit that has been reached, it may continue to accept ICEP (i.e., conversion) enrollments only if there are reserved vacancies set aside. If there are no reserved vacancies, or once all of these vacancies have been filled, the MA organization cannot accept any new enrollees into the MA plan until space becomes available. Refer to §40.5.1 for more information on enrollment processing after reaching capacity.

Refer to §40.5 of this chapter for additional information on enrollment processing during closed periods.

If an MA organization has an MA plan that is approved by CMS for a capacity limit, it should estimate when a capacity limit will be reached and notify CMS and the general public 30 calendar days in advance of the closing of the open enrollment process. If CMS approves the capacity limit for immediate closing of enrollment, the MA organization must notify the general public within 15 calendar days of CMS approval that it has closed for enrollment.

Exhibit 23 contains three model notices that MA organizations can use to notify the public when they are closing for enrollment. **NOTE:** Public notices must receive CMS approval under the usual marketing review process.

When an MA organization has a plan that re-opens after being closed during an OEP or as a result of a capacity limit, there is no requirement for the MA organization to notify the general public. However, the MA organization should notify CMS when this occurs.

40 - Enrollment Procedures

42 CFR 422.66

An MA organization must accept *enrollment request*s it receives, regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms defined by CMS.

An individual must complete an enrollment *request* mechanism to enroll in an MA plan, **even if that individual is electing an MA plan in the same MA organization in which he/she is enrolled**, *and submit the enrollment request to the MA plan during a valid enrollment period*. If an individual wishes to elect another MA plan in the same MA organization, he/she must complete a new enrollment *request* to enroll in the new MA plan. In addition to other CMS approved *enrollment request* methods, a short enrollment form (refer to Exhibit 3 for a model short enrollment form) OR a model plan selection form (Exhibit 3a) may be used to make the *enrollment request* of another plan in the same organization in place of the comprehensive individual enrollment form. With the exception of forms that are faxed to the MA organization, individuals should submit original, not photocopied, forms. Individuals who are currently MA enrollees in an organization may also elect to enroll in another MA plan in the same MA organization via other enrollment *request* methods described in this chapter, if the MA organization offers these options. Enrollment may also be made via Auto- and Facilitated enrollment processes as described in §*40.1.5* of this chapter and via the group enrollment process for employer or union sponsored plans as described in §*40.1.6*.

Upon receiving an enrollment request, an MA organization must provide within 10 calendar days, one of the following:

- Acknowledgement notice (as described in section 40.4.1);
- Request for additional information (as described in 40.2.2); or
- Notice of denial (as described in 40.2.3).

CMS will provide weekly Transaction Reply Reports (TRRs) as well as a monthly TRR. Unless otherwise directed in this guidance, the organization must provide required notices in response to information received from CMS on either the weekly or monthly TRR, whichever contains the earliest notification.

MA organizations may not delay the processing of enrollment *request*s unless the beneficiary's *enrollment request* is being placed on a waiting list, as allowed under §40.5.

Refer to §40.2.5 for MA-PD enrollments in which an individual has other qualified prescription drug coverage through an employer or union group.

Special Rule for the Annual Coordinated Election Period (AEP):

Medicare Advantage (MA) organizations 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. Brokers and agents under contract to MA organizations may not accept or solicit submission of paper enrollment forms prior to November 15th. MA

organizations and their brokers and agents also should remind beneficiaries that they cannot submit enrollment requests until November 15th.

Despite these efforts, CMS recognizes that MA organizations may receive paper enrollment forms prior to the start of the AEP on November 15th, given that marketing activities may begin *prior to this date.* If an MA organization receives *unsolicited* paper enrollment forms on or after October 1st but prior to November 15th, it must retain and process them as follows:

- Within 7 calendar days of the receipt of a paper enrollment request, the MA organization must provide the beneficiary with a written notice that acknowledges receipt of the complete enrollment request, and indicates that the enrollment will take effect on January 1 of the following year (refer to Exhibits 4, 4a and 4d for model notices).

- For AEP enrollment requests received prior to November 15th, the MA organization must submit all transactions to CMS systems (MARx) on November 15th with an "application date" of November 15th of the current year *in the appropriate data field on the enrollment transaction*. 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 MA organization receives a MARx *TRR* from CMS indicating whether the individual's enrollment has been accepted or rejected, it 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 *TRR* from CMS) provided in §40.4.2.

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 the receipt of unsolicited paper enrollment forms prior to the beginning of the AEP on November 15th. To help ensure a successful AEP season, it is imperative that plans follow these steps and submit valid enrollment transactions promptly as directed.

40.1 - Format of Enrollment *Requests*

MA organizations must have, at minimum, a paper enrollment form process (as described in this chapter and approved through the CMS marketing material review process described in the Medicare Marketing Guidelines) available for potential enrollees to elect enrollment in an MA plan. MA organizations must also process auto- and facilitated enrollment *request*s into MA-PD plans as described in §*40.1.5* of this section.

MA organizations have the option to accept enrollment *request*s as described in §§40.1.2, 40.1.3, 40.1.4 and 40.1.5 below.

40.1.1 - Enrollment *Request Mechanisms*

The MA organization must use an enrollment *mechanism* that complies with CMS' guidelines in format and content.

Specific model enrollment forms have been developed for each plan type as follows:

Exhibit 1 - MA coordinated care plans
Exhibit 1b - MSA plans
Exhibit 1c - PFFS plans

Organizations should utilize the model appropriate to the plan type for all enrollment request mechanisms to ensure all required elements are included. Plans may develop their own materials using these models subject to the CMS review and approval of plan marketing materials process. CMS has also developed a model short enrollment mechanism (Exhibit 3) and a model plan selection mechanism (Exhibit 3a) to allow for enrollment requests into another plan (PBP) within the same MA organization (H#), as well as a model EGHP enrollment mechanism (Exhibit 2). PFFS plans may use a short enrollment mechanism (Exhibit 3 or 3a) only for current members of one PFFS plan (PBP) to request enrollment into another PFFS plan (PBP) within that same organization (H#).

Enrollment mechanisms must include the applicant's acknowledgement of the following:

- *Understanding of the requirement to continue to keep Medicare Part A and B*
- *Agreement to abide by the MA plan's membership rules, as outlined in member materials;*
- *Consent to the disclosure and exchange of information necessary for the operation of the MA program;*
- *Understanding that he/she can be enrolled in only one Medicare health plan and that enrollment in the MA plan automatically disenrolls him/her from any other Medicare health plan and prescription drug plan. Note: The model PFFS and MSA enrollment mechanisms provide language as appropriate; and*
- *Understanding of the right to appeal service and payment denials made by the organization.*

Please refer to *Appendix 2 for a complete listing of required elements that must be included on enrollment mechanisms and* Exhibits 1 – 3a for complete information on the required statements.

Special Needs Plans (SNPs) must include elements on the enrollment mechanism that correspond to the special needs focus of the particular SNP.

Medical Savings Plans (MSA) must include elements on the enrollment form as provided in Exhibit 1b.

No enrollment form or other enrollment *request* mechanism may include a question regarding *binding arbitration,* whether the individual receives hospice coverage (except MSA plans) or any other health screening information, with the exception of questions regarding ESRD status and nursing home status (some additional exceptions apply for SNPs; please refer to §40.2, item "D" of this chapter).

Refer to §60.9 for requirements regarding retention of enrollment *request mechanisms*.

40.1.*2* - Enrollment via the Internet

MA organizations may develop and offer enrollment *request*s into an MA plan via *the organization's* secure internet web site. The following guidelines must be applied in addition to all other program requirements:

- Submit all materials and web pages for CMS approval following the established process for the review and approval of marketing materials
- Provide beneficiaries with all the information required by CMS' marketing guidelines for the MA program
- At a minimum, comply with CMS' internet security policies (found at: *http://www.cms.hhs.gov/informationsecurity/* on the web). *The MA organization 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 MA organization
- Capture the same data as 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
- If a legal representative is completing this *enrollment request* mechanism, s/he must attest that s/he has such authority to make the *enrollment request* and that proof of this authority is available upon request by the MA organization or CMS
- Inform the individual of the consequences of completing the internet enrollment, including that s/he will be enrolled (if approved by CMS), and that s/he will receive notice (of acceptance or denial) following submission of the enrollment to CMS
- Include a tracking mechanism to provide the individual with evidence that the internet enrollment request was received (e.g. a confirmation *of receipt* number).

- *Optionally,* may request or collect premium payment or other payment information, such as a bank account number or credit card numbers.

- Maintain electronic records that are readily reproducible for the period required in §60.8 of this chapter. The organization's record of the *enrollment request* must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member and/or CMS. A data extract file alone is not acceptable.

- *The option of online enrollment is available on the MA organization's website.*

Medicare Online Enrollment Center

In addition to the process described above, CMS offers an on-line enrollment center *(OEC)* through the www.medicare.gov web site and the 1-800-MEDICARE Call Center for enrollment into Medicare Advantage plans *(except for MSA)* and Medicare prescription drug plans. The date and time "stamped" by the Medicare Online Enrollment Center will serve as the application date for purposes of determining the election period and enrollment effective date. *MA organizations must promptly retrieve enrollment requests from the OEC and should check for requests at least daily.*

40.1.*3* - Enrollment via Telephone

MA organizations may accept requests for enrollment into their MA plans via an incoming (in-bound) telephone call *to a plan representative or agent*. The following guidelines must be followed, in addition to all other applicable program requirements:

- Enrollment requests may be accepted only during an incoming (or in-bound) telephone call from a beneficiary. *This includes inbound calls to an incorrect department or extension transferred internally.*
- Individuals must be advised that they are completing an enrollment *request*.
- Each telephonic enrollment request must be recorded (audio) and include a statement of the individual's agreement to be recorded, all 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 *reproducible and* maintained as provided in section §60.8.
- Collection of financial information (e.g. a credit card or bank account number) 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 §40.4.1.

The MA organization must ensure that all MA eligibility and enrollment requirements provided in this chapter are met. Scripts for completing an enrollment request in this manner must be developed by the MA organization. The scripts must contain the required elements for completing an enrollment request as described in Appendix 2, and must receive CMS approval in accordance with CMS Marketing Guidelines before use.

40.1.*4* - Seamless Conversion Enrollment Option for Newly Medicare Advantage Eligible Individuals

MA organizations may develop processes to provide seamless enrollment in an MA plan for newly Medicare Advantage eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as commercial or Medicaid plans) at the time of their conversion to Medicare. CMS will review an organization's proposal and must approve it before use. *MA organizations must send proposals* to the *appropriate* Regional Office *account manager* and must meet the *following* conditions.

- A description of the MA organization's process to identify individuals currently enrolled in a health plan offered by the organization. Such process must be able to identify these individuals no later than 120 days prior to the date of initial Medicare eligibility (the conversion date).

- A description of the outreach activity associated with the seamless conversion process including a written notice provided to each individual at least 90 days prior to the date of conversion. The notice must include clear information instructing the individual on how to opt-out, or decline, the seamless conversion enrollment.

- The process to opt-out or decline the seamless conversion enrollment must include both the opportunity to contact the MA organization in writing or by telephone to a toll-free number. The MA organization is prohibited from discouraging declination.

- Enrollment transactions submitted to CMS for these cases must always use the first day of an individual's ICEP as the application date in the transaction record. Doing so ensures that any subsequent action taken by the individual will take precedence in systems processing. In addition, the enrollment effective date must always be the date of the individual's first entitlement to **both** Medicare Part A and Part B.

- Plans must have beneficiary information, including HICN, date-of-birth and sex in order to process seamless conversion enrollments.

40.1.*5* - Auto- and Facilitated Enrollment

All LIS eligible individuals who elect an MA plan without Medicare prescription drug benefits ("MA-only plan") effective 2006 or later, will be auto- or facilitated enrolled into an MA-PD plan in the same organization. The auto- and facilitated enrollment processes will occur monthly. As noted in the preamble to the final regulation for Part D (Federal Register/Vol. 70, No. 18, January 28, 2005), the legal authority for both auto- and facilitated enrollment processes is technically termed "facilitated" enrollment, since auto-enrollment is limited to PDPs. However, the term "auto-enrollment" is used here to denote the process that applies to full-benefit dual eligible individuals, and "facilitated enrollment" to others with LIS.

CMS has safeguards in place to prevent existing MA and cost plan enrollees from being auto- or facilitated enrolled by CMS into a PDP. However, there may be instances in which a beneficiary *request to enroll* into an MA plan will not have been processed at the

point in time when PDP auto- or facilitated enrollment occurs. In these cases, the beneficiary will receive a notice from CMS informing him/her that s/he has been enrolled into a PDP. However, once the beneficiary*'s request to enroll* into the MA organization is processed, it will prevail over the auto- or facilitated enrollment made by CMS.

Please note this section does not apply to MA organizations that only offer MA-PD plans, as all their enrollees already have Part D coverage. Nor does it apply to PFFS plans offered by organizations that do not offer any MA-PD plans (these beneficiaries qualify for the standard CMS auto-enrollment process into PDPs), nor to MA organizations in the U.S. territories, including Puerto Rico.

A. Populations

1. Auto-Enrollment

Full-benefit dual eligibles in MA-only plans will be auto-enrolled by the MA organization into an MA-PD plan. 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). 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). In Part D, these distinctions are key to distinguishing full-benefit dual eligibles, who need to be auto-enrolled, from other types of dual eligibles, who need to be facilitated enrolled.

Full-benefit dual eligible individuals to be auto-enrolled include those who are full-benefit dual eligible upon initial enrollment into an MA-only plan, as well as existing Medicare enrollees of an MA-only plan who become newly Medicaid eligible. This includes full-benefit dual eligible MA-only enrollees who:

- Live in the 50 states or the District of Columbia; and
- Regardless of whether the employer is claiming the retiree drug subsidy for that individual, or whether the individual is enrolled in an employer-sponsored MA-only plan, including MA-only "800" plans. Please see subsection F for specialized auto-enrollment procedures for these individuals.

This excludes full-benefit dual eligibles who:

- Live in any of the five U.S. territories;
- Live in another country;
- Are inmates in a correctional facility; or
- Have opted out of auto-enrollment into Part D benefits
- [For MA-PFFS only] Are already enrolled in a stand-alone Prescription Drug Plan

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 premiums and/or 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 level of the LIS.

Other LIS eligible individuals to be facilitated enrolled include those who are Other LIS eligible upon initial enrollment into an MA-only plan, as well as existing Medicare enrollees of an MA-only plan who become newly Other LIS eligible.

This includes Other LIS eligible MA-only enrollees who:

- Live in the 50 states or the District of Columbia.

This excludes Other LIS eligible individuals who:

- Live in any of the five U.S. territories,
- Live in another country,
- Are individuals for whom the employer or union is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored MA-only plan, including MA-only "800 series" plans,
- Are inmates in a correctional facility, or
- Have opted out of facilitated enrollment into the Part D benefit.
- [For MA-PFFS only] Are already enrolled in a stand-alone Prescription Drug Plan

B. Auto/Facilitated Enrollment Process

The procedure for auto/facilitated enrollment is as follows:

1. The MA organization will identify full-benefit dual eligibles to be auto-enrolled, and Other LIS eligibles to be facilitated enrolled. Please see subsection C for details on how to distinguish the two populations.

   a. For full-benefit dual eligibles in an employer-sponsored MA-only plan, including "800" series plans, or with RDS, please follow the special procedures in section F.

   b. For PFFS plans, the organization must exclude individuals who are already enrolled in a stand-alone PDP. The organization may submit a Batch Eligibility Query (BEQ) transaction or access the MARx online query (M232 screen) to determine whether individuals are enrolled in a stand-alone PDP.

2. The MA organization will then identify MA-PD plans in the same service area, and in the same MA organization, with the lowest combined Part C and Part D premium amount. If more than one MA-PD plan have the same lowest premium amount, auto-enrollment must be random among the available MA-PD plans. The selection of MA-PD plan is without regard to the Part C premium or cost-sharing.

If an MA Special Needs Plan (SNP) meets these criteria, the MA organization must ensure that the individual meets the eligibility criteria for the SNP (e.g. type of dual eligible, type of chronic condition, or institutionalized). Please note the "MA full dual file" uses LIS deemed reason code to identify full duals, meaning they were full dual in at least one month in the past year. If the MA SNP does not meet the criteria of lowest combined Part C and D premium, the MA organization may not auto-enroll full benefit dual eligibles into it, even if it is a dual eligible SNP.

For PFFS plans, if the organization offers a stand-alone PDP in the same region with a basic benefit and a premium at or below the low-income premium subsidy amount for that region, the organization may auto/facilitate enrollment into that PDP. Organizations offering both an MA-PD PFFS plan and a stand-alone PDP must choose to auto/facilitate enroll into either the MA-PD plan or the PDP and must apply this policy consistently for all PFFS plans offered by the organization.

3. Within 10 calendar days of identifying an individual as needing auto/facilitated enrollment, the MA organization sends an auto/facilitated enrollment notice to the beneficiary (see Exhibits 27, 27A, 28 and 28a).

4. If the person does not respond or opt-out by the deadline below, submit a Code 71 transaction (PBP change) for the auto/facilitated enrollment into the MA-PD plan and include the appropriate effective date (see subsection C). The new MA-PD plan will be notified of the auto/facilitated enrollment via a transaction reply.

    - Auto-enrollment – within 14 calendar days of sending notice
    - Facilitated enrollment – by last day before effective date of facilitated enrollment

C. Effective Date of Auto/Facilitated Enrollments

1. Auto-Enrollment

The effective date of auto-enrollment is retroactive to the first day of the month the individual first became a full-benefit dual eligible, or January 1, 2006, whichever is later. For individuals who are full-benefit dual eligible upon enrollment into an MA-only plan, the effective date would be retroactive to the effective date of enrollment in the MA-only plan. For existing MA-only Medicare enrollees who subsequently become Medicaid eligible, the effective date is retroactive to the first day of the month the person became Medicaid eligible. In no case will the effective date of auto-enrollment precede the date that the individual became an enrollee of the MA organization.

There is nothing that prohibits a full-benefit dual eligible from initially electing an MA-only plan. To ensure they understand the consequences of doing so, marketing material and the acknowledgement letter emphasizes that prescription drugs are not covered.

2. Facilitated Enrollment

The effective date of facilitated enrollment for all Other LIS eligible members is the first day of the second month after the person is identified as qualifying for facilitated enrollment. For example, if the plan is notified in August 2006 that an existing member of an MA-only plan has become LIS eligible, the effective date is October 1, 2006.

The MA organization may 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 start of earlier month. If the person is a full or partial dual eligible, the SEP under §30.4.4 #5 should be used. If the person is a non-dual LIS eligible, the SEP in §30.4.4 #12 is available.

> Example: The MA organization facilitates enrollment of an Other LIS eligible in May, 2007, effective July 1, 2007. The beneficiary receives the facilitated enrollment by the last day in May, and requests the MA organization makes the facilitated enrollment effective June 1. The MA organization submits an enrollment transaction to do so.

3. Distinguishing Between Full-Benefit Dual Eligible and Other LIS Individuals

MA organizations need to distinguish full benefit dual eligibles from others with LIS for purposes of setting the effective date. The first step is to identify all LIS eligibles in the MA-only plan. CMS does not transmit a data element to plans that can be used to distinguish full-benefit dual eligibles from other LIS. As a result, CMS sends a monthly "Auto Assignment Full Dual Notification File" (for file format and technical specifications, please see section 8.1 of the Plan Communications User Guide, on the CMS website at http://www.cms.hhs.gov/medicaremangcaresys/01_overview.asp). This file identifies full-benefit dual eligibles.

Use the Auto Assignment Full Dual Notification File to identify the subset of the LIS enrollees in the MA-only plan who are full-benefit dual eligibles. To determine the auto-enrollment effective date, identify the LIS copay start date data provided on other files (e.g. *TRRs* and LIS bi-weekly file). As noted above, there is no data element that distinguishes full-benefit dual eligibles from other LIS eligibles, so organizations must use the Full Dual Notification File to identify this group, then identify the start date of their current LIS copay effective date to determine the auto-enrollment effective date.

The remaining LIS eligibles in the MA-only plan qualify for facilitated enrollment, and the effective date should be set as noted in item 2 above.

D. Notice

The MA organization will notify the beneficiary in writing that she/he will be enrolled in the given MA-PD plan on the specified effective date. The notice must be sent within 10 calendar days of identifying the individual as qualifying for auto/facilitated enrollment. The notice will inform the beneficiary that they may choose another Part D plan (either another MA-PD plan or Original Medicare with a PDP) or opt out of auto/facilitated enrollment into the Part D benefit. If the beneficiary does not opt out, or choose another Part D plan within the specified deadline, the person's silence will be deemed to be an election of the auto/facilitated enrollment and it will take effect on the effective date. These individuals will also be informed they have a Special Enrollment Period (SEP) that

permits them to change Part D plans, even after the auto/facilitated enrollment takes effect.

1. Auto-Enrollment

Please use the model notice language in Exhibit 27. For MA-PFFS auto-enrolling into a PDP, please use Exhibit 27a. The deadline for responding is 14 calendar days from when the notice is sent. The SEP available is continuous (i.e. full-benefit dual eligibles may change plans in any month).

2. Facilitated enrollment

Please use the model notice language in Exhibit 28. For MA-PFFS auto-enrolling into a PDP, please use Exhibit 28a. The deadline for responding is the last day before the facilitated enrollment effective date. The SEP available is continuous.

E. Opt-Out

Full-benefit dual eligible and Other LIS individuals may opt-out, or affirmatively decline, the Part D benefit. Beneficiaries may opt-out verbally or in writing. For an MA-only plan enrollee, this primarily means declining auto/facilitated enrollment into an MA-PD plan in the same organization and maintaining enrollment in the MA-only plan. MA organization may check the common User Interface to see if the individual has previously opted out; if so, the person should not be auto/facilitated enrolled. Once a beneficiary has opted out, the MA organization should document this and not include them in future auto-enroll processing.

The MA plan should counsel the individual to ensure they understand the implications of their request to decline, and should confirm this in writing (see Exhibit 29) within 10 calendar days of identifying the individual as qualifying for auto/facilitated enrollment. If a beneficiary opts out of auto/facilitated enrollment by the deadline in the auto/facilitated notice, do not submit an enrollment transaction that would move them to an MA-PD plan. This will have the effect of leaving them in the MA-only plan.

If the individual opts-out after the Code 71 transaction has been submitted, the effective date of returning to the MA-only plan is normally prospective, i.e. first day of the following month. However, through the 15th of the month after the month in which the notice was sent, at a full-dual eligible's request, the MA organization may restore the person to the MA-only plan retroactive to the auto-enrollment effective date. This is accomplished by submitting a Code 71 transaction with the same effective date, and setting the opt-out flag as noted below.

Individuals who want to opt-out of auto/facilitated enrollment into an MA-PD plan must do so with their MA organization, not through 1-800-MEDICARE. This differs from the procedure for individuals who want to opt-out of auto/facilitated enrollment into a stand-alone PDP. If a 71 transaction has already been submitted to move the person to the MA-PD plan, the MA organization sends another 71 transaction (to move the person back to the MA-only plan), setting the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment)

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. To obtain Part D benefits, the beneficiary simply makes a voluntary *request to enroll* into a plan that offers Part D benefits.

F. Special Procedures for Individuals With Employer Coverage

It is possible the MA organization will not be aware an individual has RDS until they submit a Code 71 transaction to auto/facilitate his/her enrollment. As with all enrollment transactions for individuals with RDS, MARx will enforce a two-step process, initially rejecting the transaction. The MA organization must follow normal procedures of confirming with the beneficiary that she/he wants to be enrolled in the Part D benefit and, if confirmed, resubmit the transaction with the employer subsidy override.

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.

G. Information Provided to Auto/Facilitated Enrolled Beneficiaries

The MA-PD plan into which the beneficiary has been auto/facilitated enrolled must send a modified version of the pre- and post-enrollment materials required to be provided to new enrollees. If the effective date is retroactive into the previous calendar year, only send the current year's version of the documents below.

Prior to effective date, the MA-PD plan must send:

- The information required in §40.4.1, 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/facilitated enrolled or change to another one that better meets their needs). Providing the Summary of Benefits, which is considered marketing material normally provided prior to making an enrollment *request*, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.

After the effective date of coverage:

- The guidance in §40.4.2 applies, including guidance on what to do if the MA-PD plan is not notified early enough of an auto/facilitated enrollment to meet the timelines in §40.4.1 on materials required to be provided prior to the effective date.

H. Summary of Differences Between Auto- and Facilitated Enrollment Processes

	Auto-Enrollment of Full Duals	**Facilitated Enrollment of Other LIS**

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Frequency	Monthly	Monthly
Steps	• Identify full dual eligibles in MA-only plan who need to be enrolled into MA-PD plan • Send notice to beneficiary within 10 calendar days of identifying need for person to be auto-enrolled • If no answer or person does not opt out within 14 calendar days, submit 71 transaction to move to MA-PD plan	• Identify non-full dual LIS beneficiaries in MA-only plan who need to be enrolled into MA-PD plan • Send notice to beneficiary within 10 calendar days of identifying need for person to be facilitated enrolled • If no answer or person does not opt out by last day before effective date of facilitated enrollment, submit 71 transaction to move to MA-PD plan
Who needs to be moved	• Full dual who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became Medicaid eligible and is thus newly full dual	• Non-full dual with LIS who newly enrolls in MA-only plan • Beneficiary in MA-only plan who recently became LIS-eligible
Who does not need to be moved	• Those who have already opted out • Those with RDS or employer coverage who do not consent to auto-enrollment	• Those who have already opted out • Those with RDS • Those in "800 series" employer sponsored group plans • Those in employer sponsored plans (other than "800 series" plans)

Data to identify those in MA-only plan who need to be moved to MA-PD plan	Monthly MA full dual file	LIS data (either TRR, or bi-weekly LIS file): • Premium subsidy = 25, 50, 75 OR • Premium subsidy = 100 AND o LIS copay = 4 (15%) Or • LIS copay = 1 ($2/5) AND person is not

		on MA full dual file
Plan Into Which Beneficiary Should be Enrolled	MA-PD plan with the lowest combined Part C and D premium	MA-PD plan with the lowest combined Part C and D premium
Notice to send	Exhibit 27	Exhibit 28
Application date on transaction	First day of month prior to effective date of the enrollment	First day of month prior to effective date of the enrollment
Enrollment type	S = Special Enrollment Period	S = Special Enrollment Period
Effective date	• First day of month person qualified for LIS (will be retroactive) • Cannot be prior to start of enrollment in the MA-only plan	• First day of second month after person identified as needing enrollment • Cannot be prior to start of enrollment in the MA-only plan
Opt out	• Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 29) • If submitting 71 transaction to move beneficiary back to MA-only, set Opt-Out flag to Y (field 38)	• Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 29) • If submitting 71 transaction to move beneficiary back to MA-only, set Opt-Out flag to Y (field 38)

40.1.6 – Additional Enrollment Request Mechanisms for Employer/Union Sponsored Coverage

MA organizations may choose to accept voluntary enrollment requests directly from the employer or unions who sponsor MA coverage for its members in any of the enrollment mechanisms described in this guidance (except auto or facilitated enrollment). In addition, the MA organization may also accept enrollment requests using either the optional enrollment request mechanism or group enrollment process described in this section.

It is the MA organization's responsibility to ensure that all applicable MA enrollment requirements are met, regardless of the process utilized, as required by CMS. In any case, the enrollment requests provided to the MA organization by the employer or union will reflect the choice of retiree coverage individuals made using their employer's or union's process for selecting a health plan.

For enrollment processing purposes, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of enrollment into the employer or union group-sponsored plan.

40.1.6.1 - Group Enrollment Mechanism

CMS will allow an employer or union to enroll its retirees using a group enrollment process in which beneficiaries enroll in an employer or union sponsored MA plan . Beneficiaries participate in this process through advance notification that provides each individual with all the information necessary to make an informed choice.Furthermore, the process must provide CMS with any information the employer/union has on other insurance coverage for the purposes of coordination of benefits. It is the MA organization's responsibility to ensure the group enrollment process meets all applicable MA enrollment requirements. MA organizations must ensure that any 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 providing the following information to each beneficiary as follows:

- *Beneficiaries participate in the group enrollment mechanism by receiving an Advance notice that the employer/union intends to enroll them for a prospective coverage effective date in an MA plan that the employer/union is sponsoring; and*
- *Clear instruction that the beneficiary may affirmatively opt out of such enrollment; explaining the process to opt-out; and any consequences to employer or union benefits opting out would bring; and*
- *This notice must be provided by either the MA organization, employer or union not less than 21 calendar days prior to the effective date of the beneficiary's enrollment in the employer/union sponsored MA plan.; and*
- *Additionally, the information provided to each beneficiary must include a Summary of Benefits offered under the employer/union sponsored MA plan, as well as an explanation of how to get more information about the MA plan, and an explanation on how to contact Medicare for information on other Medicare Health Plan options that might be available to the beneficiary.; and*
- *Each individual must also receive in the group enrollment notice materials the information contained in Exhibit 2 under the heading "Please Read & Sign Below."*

For enrollment processing purposes, the application date on the enrollment transaction submitted to CMS 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/union must provide all the information required for the MA organization to submit a complete enrollment request transaction to CMS in the group enrollment file(s). (*refer to Appendix 2 of this chapter for a complete list of the required data elements and any other relevant CMS systems guidance). Records must be maintained as outlined in §60.8 of this chapter.*

40.1.6.2 - Optional Mechanism For MA Group-sponsored plan Enrollment

This enrollment request mechanism is optional for MA organizations and may not be required. Therefore, MA organizations may specify the employers or unions, if any, from which they will accept this enrollment request format. It is the MA organization's

responsibility to ensure that the process it uses, as well as the process used by the employer or union, meets the following requirements:

The MA organization must inform its Regional Office Account Manager of its intent to use this mechanism and identify the employer group(s) or union(s) for which it will be accepting enrollments made in this manner.

The enrollment information (i.e., the electronic file) submitted to the MA organization by an employer or union (or TPA) must accurately reflect the employer's or union's record of the election of coverage made by each individual according to the processes the employer or union has in place, and may be accepted without a paper MA enrollment request form.

Sales package minimum information requirements are not changed by using this option. These include, but are not limited to, providing the applicable rules of the MA organization. Each individual's enrollment request must clearly denote his/her agreement to abide by the MA organization rules, certify his/her receipt of required disclosure information and include authorization by the beneficiary for the disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (and its designees) and the MA organization. The requirements for all other information provided to enrollees, both pre- and post-enrollment, are unchanged by this option and must be satisfied.

The enrollment request transaction must include all the data necessary for the MA organization to determine each individual's eligibility to make an enrollment request as described in §20 of this chapter of the MMCM. Agreements with employer groups or unions should identify required data elements. A detailed list of these elements is provided as Appendix 2.

This alternate enrollment request mechanism is used in place of paper MA enrollment request forms and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the application date of enrollment requests made in this manner will be the first day of the month prior to the effective date of enrollment into the employer/union sponsored plan. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the enrollment submitted by the employer or union.

Effective date calculation of voluntary enrollment requests and the collection and submission of enrollment requests to CMS will follow existing procedures.

To accept electronic records of employer or union enrollment requests, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information. (See the CMS web site at: http://www.cms.hhs.gov/informationsecurity for additional information.)

The employer's or union's record of the request to enroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual

member, the MA organization and/or CMS, as necessary, and be maintained (by the employer/union or the MA organization, as they agree) following the guidelines for MA enrollment request forms (see §60.9). Included in this requirement is the MA organization's record of information received from the employer or union.

40.1.*7* - Enrollment for Beneficiaries in Qualified State Pharmaceutical Assistance Programs (SPAPs)

CMS will allow qualified SPAPs to submit enrollment requests in an agreed-upon electronic file format to MA Organizations as follows:

- The SPAP must attest, as required by §40.2.1 of this guidance that it has the authority under state law to enroll on behalf of its members.
- The SPAP must coordinate with the MA Organization 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 it is enrolling on their behalf, how the enrollment works with the SPAP and how individuals can decline such enrollment.

In return, MA organizations that agree to accept mass enrollment *request*s from SPAPs are required to process them like any other enrollment and in accordance with notification timeframes. It is important for the MA organization 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 employer or union sponsored drug coverage (to confirm that the individual understands the implications of enrolling in a Part D plan).

Special note for SPAP enrollment requests during the AEP - *For enrollment processing purposes, the application date on the enrollment transaction submitted to CMS must be set to November 15th with the effective date of January 1st and the election period identifier of "A" (for AEP). This will ensure that subsequent beneficiary-generated enrollment requests made during the AEP will supersede the SPAP enrollment in CMS systems.*

40.2 - Processing the Enrollment Request

If an enrollment form or other enrollment mechanism is completed during a face-to-face interview, the MA organization 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 enrollment in Part B. If the form is mailed or faxed to the MA organization, or the *enrollment request* is made through another CMS approved method, the MA organization 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 form. *Regardless of whether or not the MA organization has reviewed the Medicare Identification card, the MA organization must still validate and verify Medicare entitlement as described in item "B" below in this section.*

Appendix 2 lists all the elements that must be filled out in order to consider an enrollment *request* "complete." If the MA organization receives an enrollment *request* that contains all these elements, the MA organization must consider the enrollment complete even if all other data elements on the enrollment *request* are not filled out. If an MA organization has received CMS approval for an enrollment *request* that contains data elements in addition to those included in Appendix 2, then the *election request* is considered complete even if those additional elements are incomplete.

If an MA organization receives an enrollment *request* that does not have all necessary elements required in order to consider it complete, it must not deny the enrollment. Instead, the enrollment is considered incomplete and the MA organization must follow the procedures outlined in §40.2.2 in order to complete the enrollment. The MA organization must always check available systems (i.e. BEQ, MARx online query) 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 MA organization could obtain this information via available systems rather than request the information from the beneficiary.

For EGHP enrollees, the MA Organization may choose to accept enrollment *request*s as described in §40.1.2 or §*40.1.6*. All required elements as listed in Appendix 2 must be included in the record *of the enrollment request provided by the group* for the *enrollment request* to be considered complete (except signature). Follow the procedures outlined in §40.2.2 to address incomplete *enrollment* requests.

For enrollment *request*s via the Internet *and telephone*, as described in §40.1.3 *and §40.1.4*, all required elements as listed in Appendix 2 must be included except a pen-and-ink signature. The individual enrolling via this method indicates his or her intent to enroll by completing the on-line process (as described). Follow the procedures outlined in §40.2.2 to address incomplete *enrollment request*s.

The following should also be considered when completing an enrollment:

A. Permanent Residence Information - The MA organization *must* determine *whether or not the enrollee* resides within the MA plan's service area. If an individual puts a Post Office Box as his/her place of residence on the enrollment *request*, the MA organization *must* consider the enrollment *request* 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 MA organization should consult the State law in which the MA organization operates and determine whether the enrollee is considered a resident of the State.

Refer to §10 for a definition of "evidence of permanent residence," and §20.3 for more information on determining residence for homeless individuals.

B. Entitlement Information - Following the procedures outlined in the CMS Plan Communications User Guide, MA organizations must verify Medicare entitlement using the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen) for all enrollment requests, *except enrollment requests from*

a current enrollee of an MA plan who is requesting enrollment into another MA plan offered in the same contract (H#) with no break in coverage (i.e. "switching plans").

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

When neither the BEQ, *the* MARx online query, *or MAPDIUI beneficiary eligibility query* show Medicare entitlement, *as a final attempt to confirm a beneficiary has Medicare,* the organization *must* consider the individual's Medicare ID card *to be evidence of Medicare entitlement. When neither the BEQ/MARx query nor the Medicare ID card are available, the MA organization must consider an SSA Award Letter that shows Medicare entitlement (including start dates)* as evidence of Medicare entitlement.

If the organization is not able to verify entitlement *as described above*, refer to §40.2.2 for additional procedures.

For Auto and Facilitated enrollments, as described in §*40.1.5* of this chapter, entitlement verification is deemed complete, as the individual is already an MA enrollee.

C. Effective Date of Coverage - The MA organization must determine the effective date of coverage as described in §30.5 for all enrollment *request*s. If the individual fills out an enrollment form in a face-to-face interview, then the MA organization 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 MA organization to confirm the actual effective date. The MA organization must notify the member of the effective date of coverage prior to the effective date (refer to §40.4 for more information and a description of exceptions to this rule), and must write the actual effective date on the enrollment form where applicable.

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date (effective dates are described in §30.5). Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face enrollments, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §30.5.

If a beneficiary completes an enrollment *request* with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must notify the beneficiary in a timely manner and explain that the enrollment 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 notification must be documented. If the beneficiary refuses to have the enrollment processed with the correct effective

date, the beneficiary can cancel the *enrollment request* according to the procedures outlined in §60.2.1.

MA organizations must ensure enrollees have access to plan benefits as of the effective date of enrollment the MA organization has determined and may not delay provision of plan benefits in anticipation of the submission to or reply from CMS systems.

For auto and facilitated enrollments, refer to §*40.1.5* of this chapter for more information.

D. Health Related Information - MA organizations may not ask health screening questions during completion of the enrollment *request*. MA organizations are only permitted to send health assessment forms after enrollment. However, MA organizations may ask very limited health status questions related to a beneficiary's eligibility to join an MA plan such as whether the individual has ESRD, is enrolled in Medicaid, or is currently admitted to a certified Medicare/Medicaid institution. Queries for this information are included on the model individual enrollment form in Exhibit 1, and the model EGHP form in Exhibit 2. These queries are not considered to be health screening questions. With the exception of information obtained on ESRD status, the responses to these questions must not have an affect on eligibility to enroll in an MA plan.

Exception for certain MA-SNPs - An SNP that is being offered to individuals with certain medical conditions (i.e. an SNP for chronic and disabling conditions), as permitted by CMS, will need to establish that the individual has such a condition to determine eligibility for enrollment in that specific SNP. Refer to §20.11 for more information.

E. Statements of Understanding - As outlined in §20.5, a beneficiary must understand and agree to abide by the rules of the MA plan in order to be eligible to enroll. *If the MA organization lists such statements in an itemized format, i*t is at the MA organization's discretion to decide whether it will:

- *C*onsider the beneficiary signature on the form (or completion of the *enrollment request* process) to signify that the individual has read and understands the statements (as shown on Exhibits 1, 1b, 2 and 3); or

- Have fields next to the statements and require the applicant's initials next to each statement.

The MA organization must apply the policy consistently. If the MA organization requires the initials and the applicant fails to initial his/her understanding of each item listed on the enrollment form, the MA organization may contact the applicant to clarify the MA organization rules in order to complete the enrollment form. The MA organization must document the contact and annotate the outcome of the contact. If the MA organization is unable to contact the applicant to ensure their understanding, the enrollment form would be considered incomplete.

F. Applicant Signature and Date - The individual must sign the enrollment form or complete the enrollment *request* mechanism. If the individual is unable to do so, a legal representative must sign the enrollment form (refer to §40.2.1 for more detail) or complete the *enrollment request* mechanism. If a legal representative enrolls an individual, the legal representative must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an *enrollment request* on behalf of the applicant is available and can be presented upon request by the MA organization or CMS.

The individual and/or legal representative must indicate his/her relationship to the individual and date he/she signed the enrollment form or completed the enrollment *request*; however, if he/she inadvertently fails to include the date on the enrollment *request*, then the date the MA organization receives the *enrollment request* may serve as the signature date of the form.

If a paper enrollment form is submitted and the signature is not included, the MA organization may verify with the individual with a phone call and document the contact, rather than return the paper enrollment form as incomplete. *The documentation of this contact will complete the enrollment request (assuming all other required elements are complete).*

Certain *enrollment request* mechanisms do not include a pen-and-ink, or "wet," signature. Follow the specific procedures provided for the other *enrollment request* mechanism in this chapter; for example, see §40.1.3 for information about enrollment via the internet.

For auto and facilitated enrollment as described in §*40.1.5*, an enrollee signature is not required.

G. Other Signatures - If the MA organization representative helps the individual fill out the enrollment form, then the MA organization representative must also sign the enrollment form. However, the MA organization 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 MA organization 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 MA organization receives an enrollment request that was executed more than 30 calendar days prior to the MA organization's receipt of the request, the MA organization 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 - The MA organization must date all enrollment *request*s as soon as they are initially received. Except for enrollment requests submitted via the CMS Online Enrollment Center, requests made by the group enrollment mechanism and auto or facilitated enrollments, the date the enrollment *request* is initially received is equivalent to the "application date" (refer to §10 for definitions of "receipt of *enrollment request*," "completed *enrollment request*" and "application date"). If the enrollment *request* is not complete at the time it is received, then the additional documentation required for the enrollment *request* to be complete must be dated as soon as it is received. *Appendix 3 describes the appropriate application date to include in the enrollment transaction submitted to CMS under various conditions.*

J. Final Verification of Information - Some MA organizations verify information before enrollment information has been transmitted to CMS. In these cases the MA organization may find that it must make corrections to an individual's paper enrollment form. The MA organization should make those corrections, and the individual making those corrections must place his/her initials and the date next to the corrections. A separate "correction" sheet, signed and dated by the individual making the correction, may be used by the MA organization (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 MA organization having to co-sign the enrollment form.

K. Premiums Owed to the MAO - For individuals enrolling in an MA-only (non MA-PD) plan, an MA organization may choose to wait for an enrolling individual's payment of the MA-only plan premium before considering the enrollment *request* complete. An MA organization cannot consider an enrollment *request* incomplete if the individual enrolling has indicated that he or she wants the plan premium withheld from an SSA benefit check.

For enrollment into either an MA-only or MA-PD plan, an MA organization may consider an enrollment *request* incomplete if there are premium amounts due to the organization from a prior enrollment, whether or not premium withhold from an SSA benefit check is selected.

The option chosen by the MA plan to consider the application complete or incomplete must be applied consistently to all potential enrollees of the plan.

L. Completed Enrollment *Request*s - Once the enrollment *request* is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4 within the prescribed time frames. There are instances when a complete enrollment can turn out to be legally invalid. These instances are outlined in §40.6.

M. Plan Premium *Payment and Premium* Withhold Option*s* - *At a minimum, all organizations must include on all enrollment request mechanisms the option for*

individuals to: 1) pay plan premiums by being billed directly by the plan or 2) have the premiums withheld from their SSA benefit check. The plan may also choose to offer other payment methods, such as automatic deduction from the individual's bank or other financial institution or from the individual's credit card. The enrollment mechanism must also advise the individual does not select a premium payment option, the default action will be direct bill.

MA-only plans that do not have a premium may omit the "Paying your Plan Premium" section from their enrollment request mechanism. MA-PD plans that do not have a plan premium must include, at minimum, the direct bill and SSA withhold options for those individuals subject to the LEP to select how they will pay this penalty (premium); however, such plans may include introductory language to indicate that the premium payment section applies only to individuals subject to the LEP.

MA-PD plans must also include on all enrollment request mechanisms a statement in the premium payment section advising those individuals who qualify for extra help that, if the extra help does not cover the entire plan premium, the individual is responsible for the amount that Medicare does not cover.

Model language has been provided on Exhibits 1, 1c, 3 and 3a to reflect the required options. In addition, suggested optional language for MA-PD plans without premiums has also been provided.

Note: At this time, neither RRB nor OPM is able to process withhold requests.

N. Additional Information for MA-PD Enrollment *Request*s – Individuals enrolling in a Part D plan must disclose any other existing coverage for prescription drugs.

O. Part D Payment Demonstrations - Employer or union groups are prohibited from making payments of any kind on behalf of an individual enrolling in a Part D payment demonstration plan. Except for current MA enrollees who are becoming enrollees of an MA-PD Part D payment demonstration plan through the plan renewal process, each new individual enrolling in such a plan will be required to provide an attestation regarding employer or union group payment. MA organizations must include the following attestation statement along with the other required "statements of understanding" in all enrollment requests vehicles (e.g. the enrollment form) for individuals joining a Part D Payment Demonstration MA-PD plan:

> "By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of *medical services or medical coverage,* prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare *Advantage health plan or Medicare* drug plan."

40.2.1 - Who May Complete An Enrollment or Disenrollment Request

A Medicare beneficiary is generally the only individual who may execute a valid *enrollment request* for enrollment in or disenrollment from an MA plan. However, another individual could be the legal representative or appropriate party to execute an enrollment 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 an *enrollment request* for Medicare beneficiaries. For example, persons authorized under State law may be 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 or complete an enrollment mechanism due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the *enrollment 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, MA organizations should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

Where MA organizations are aware that an individual has a representative payee designated by SSA to handle the individual's finances, MA organizations 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 request. Representative payee status alone is not sufficient to enroll a Medicare beneficiary.

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

*1) A*ttest to having the authority under State law to do so*;*
*2) C*onfirm 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 and can be provided upon request to the MA organization or CMS*.* *MA organizations cannot require such documentation as a condition of enrollment; and*
3) Provide contact information.

The MA organization must retain the record of this attestation as part of the record of the enrollment *request*. CMS will provide a sample attestation as part of the model MA enrollment form (Exhibit 1). Organizations may not require such documentation as a condition of enrollment.

When an authorized representative completes an enrollment request on behalf of a beneficiary, the MA organization should inquire regarding the preference for the delivery of required notifications and other plan materials (i.e. sending mail to the beneficiary directly or to the representative, or both) and make reasonable accommodations to satisfy these wishes.

40.2.2 - When the Enrollment *Request* Is Incomplete

When the enrollment *request* is incomplete, the MA organization must document all efforts to obtain additional documentation to complete the enrollment *request* and have an audit trail to document why the enrollment *request* needed additional documentation before it could be considered complete. The organization must make this determination and notify the individual within 10 calendar days of receipt of the request that additional information is needed for the enrollment request.

For AEP *enrollment request*s, 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).

When the MA organization receives an incomplete enrollment request near the end of either a month or an enrollment period, the use of the full 21 calendar day period to complete the request may extend beyond CMS systems plan submission "cut-off" date (these dates are provided in the CMS Plan Communications User Guide). Under this specific condition, and only this condition, MA organizations may utilize a code 62 enrollment transaction to directly submit the request to CMS as provided in the CMS Plan Communications User Guide.

If additional documentation needed to make the *enrollment request* "complete" is not received within allowable time frames, the organization must deny the enrollment using the procedures outlined in §40.2.3.

Requesting Information from the Beneficiary - To obtain information to complete the enrollment *request*, the MA organization must contact the individual to request the information within ten calendar days of receipt of the enrollment request (see Exhibit 5 for a model letter). If the contact is made orally, the MA organization must document the contact and retain the documentation in its records. The MA organization must explain to the individual that the individual has 21 calendar days in which to submit the additional information or the enrollment will be denied. Since an incomplete *enrollment request* is an invalid enrollment (as explained in §40.6), if the additional documentation is not received within allowable time frames, the MA organization must send a denial of enrollment letter (see Exhibit 7 for a model denial of enrollment letter).

If all documentation is received within allowable time frames and the enrollment *request* is complete, the MA organization must transmit the enrollment to CMS within the time frames prescribed in §40.3, and must send the individual the information described in §40.4.

40.2.3 - MA Organization Denial of Enrollment

MA organization denials occur before the organization has transmitted the enrollment to CMS. An MA organization 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 MA plan and/or, (2) An individual not providing information to complete the enrollment *request* within the time frames described in §40.2.2.

Notice Requirement - The organization must send notice of the denial to the individual that includes an explanation of the reason for denial (refer to Exhibit 7 for a model notice). This notice must be sent within ten 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:

- An MA organization receives an enrollment *request* from an individual on January 7 and determines on that same day that the individual is ineligible due to place of residence. The organization should send notice of denial within ten calendar days from January 7.

- An MA organization receives an enrollment form on January 7 from an individual, identifies the enrollment form as incomplete, and notifies the individual of the need for additional information, on January 10. The beneficiary does not submit the information by January 31 (as required under §40.2.2), which means the organization must deny the enrollment. The organization should send notice of denial within ten calendar days from January 31.

40.2.4 - ESRD and Enrollment

If an MA organization is aware that an individual electing a plan no longer requires regular dialysis or has received a kidney transplant (e.g., the individual informs the MA organization that this has occurred), then the MA organization should request that the individual submit medical documentation (i.e., a letter from the physician that documents that the individual has received a kidney transplant or no longer requires a regular course of dialysis to maintain life), using the procedures outlined in §40.2.2. Upon receipt of this documentation, the MA organization should enroll the beneficiary using the override procedures described in Chapter 19 (Managed Care and MA Systems Requirements).

If an individual indicates on the enrollment *request* that he/she does not have ESRD, but the MA organization receives a *TRR* containing a “code 45” or “code 15” rejection (an explanation of transaction reply codes is contained in Chapter 19), the MA organization should investigate further to determine whether the individual is eligible to enroll. To determine eligibility, the MA organization should contact the individual to request medical documentation using the procedures outlined in §40.2.2. Contact can be made orally, in which case the MA organization must document the contact and retain the documentation in its records.

If the MA organization learns that the individual has received a kidney transplant which has restored kidney function or that the individual no longer requires a regular course of dialysis to maintain life, then the individual must be permitted to enroll in the MA plan if other applicable eligibility requirements are met. When this occurs, the MA organization must contact CMS (or its designee) to override the system rejection. The following documentation must be submitted:

1. Evidence of contact with the individual after the system rejection, including the individual's explanation for rejection (i.e., successful transplant), and medical documentation, i.e., a letter from the physician.

2. A copy of the *TRR* or, if using the services of a CMS subcontractor, a report indicating the MA organization's attempts to enroll the individual and the resulting rejection.

Once received and approved, CMS (or its designee) will override the enrollment rejection for the individual.

ESRD and MA Plan Terminations

Certain individuals with ESRD who have been impacted by MA terminations will be permitted to make one *enrollment request* into a new MA plan (refer to §20.2 for a discussion of who is eligible to make an *enrollment request*). Beneficiaries will be instructed to save their notification letters to present, if requested, to MA organizations as proof of their eligibility to join a plan. The CMS' system will edit incoming enrollment transactions for ESRD beneficiaries to determine:

1. If they were a member of a terminating or terminated MA plan; and

2. If they have already used their one *enrollment request*.

Enrollments for these individuals should be submitted as normal transactions with all other transactions. The enrollment will be allowed if the individual is eligible, and will be rejected if not.

40.2.5 - MA-PD *E*nrollment *W*hen an *I*ndividual has *O*ther *Q*ualified *P*rescription *D*rug *C*overage *T*hrough an *E*mployer or *U*nion Retiree Drug Subsidy (RDS) Plan Sponsor

CMS systems will compare MA-PD enrollment transactions to information CMS has regarding the existence of employer or union sponsored qualified prescription drug 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 as incomplete.

Within 10 calendar days of receipt of the Code 127 conditional rejection, the MA organization must contact the individual to confirm the individual's intent to enroll, and that the individual has discussed and understands the implications of enrollment in a Part D plan on his or her employer or union coverage. Individuals will have 30 calendar days from the date they are contacted to respond. The organization may contact the individual in writing (See Exhibit 6b) 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 or union coverage brought about by enrolling in the Part D Plan, and confirms s/he still wants to enroll, the MA organization 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 upon the individual's initial enrollment request. This effective date may be retroactive in the event that the confirmation step occurs after the effective date.

MA organizations are *strongly* 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 7).

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

MA organizations 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.

40.3 - Transmission of Enrollments to CMS

For all enrollment requests effective January 1, 2008, or later that the organization is not denying per the requirements in §40.2.3, the MA organization must submit the information necessary for CMS to add the beneficiary to its records as an enrollee of the MA organization within 7 calendar days of receipt of the **completed** enrollment *request*. In the case of *enrollment request*s that are accepted after the MA organization is enrolled to capacity, but as a vacancy occurs, the MA organization must submit the information within 7 calendar days after a vacancy has become available.

All enrollment elections must be processed in chronological order by date of receipt of completed enrollment elections (refer to §40.5 for procedures when the MA plan is closed for enrollment).

MA organizations are encouraged to submit transactions by the earliest possible MA organization processing cutoff date (refer to Chapter 19). However, if the organization misses the cutoff date, it must still submit the transactions within the required 7 calendar day time frame.

NOTE: The requirement to submit the transaction within 7 calendar days does not affect the effective date of the individual's coverage under the plan, i.e., the effective date must be established according to the procedures outlined in §§30.5 and 30.7.

More detail on how MA organizations must submit transmissions to CMS are contained in Chapters 19 and 20 of the Medicare Managed Care Manual.

40.4 - Information Provided to Member

Much of the enrollment information that an MA organization must provide to the member must be sent prior to the effective date of coverage. However, some information will be sent after the effective date of coverage. *A member's coverage begins on the effective date regardless of when the member receives all the information the plan sends.*

As discussed previously (§40), the organization must provide required notices in response to information received from CMS on the TRR that provides the earliest notification. In most instances, the weekly TRR will contain the earliest notification.

The organization may provide the required notices described in §§40.4.1 and 40.4.2 or may utilize a single ("combination") notice (see Exhibit 4b). *The combination notice takes the place of separate acknowledgement and confirmation notices and, as such, requires expedited issuance.* To use the combination notice, the organization must be able to provide this notice within 7 calendar days of the availability of the TRR. Additionally, when following this option to use the combination notice, if the organization is unable 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 organization still must ensure that the beneficiary has the information required in §40.4.1 within the timeframes described therein.

40.4.1 - Prior to the Effective Date of Coverage

Prior to the effective date of coverage the MA organization must provide the member with all the necessary information about being a Medicare member of the MA organization, the MA organization rules, and the member's rights and responsibilities. (An exception to this requirement is described in §40.4.2.) The MA organization must also provide the following to the individual:

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

- A notice acknowledging receipt of the completed enrollment *request* (refer to Exhibits 4, 4a, and 4d for model letters) and showing the effective date of coverage. This notice must be provided no later than 10 calendar days after receipt of the completed enrollment *request*. (Organizations choosing to use the combination notice, refer to 40.4 above)

- Proof of health insurance coverage so that he/she may begin using 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 the Medicare Marketing Guidelines. The proof of coverage may be in the form of member ID cards, the enrollment form, and/or a notice to the member (refer to Exhibits 4, 4a, 4b and 4d, which are model letters with optional language that would allow the member to use the letter as evidence of health insurance coverage until he/she receives a member card). As of the

effective date of enrollment, plan systems should indicate active membership.

Regardless of whether an *enrollment request* is made in a face-to-face interview, by fax, by mail, or by other mechanisms defined by CMS, the MA organization 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, if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).

- The prospective member's authorization for the disclosure and exchange of necessary information between the MA organization and CMS.

- The lock-in requirement. The MA organization must also obtain an acknowledgment by the individual that he/she understands that care will be received through designated providers except for emergency services and urgently needed care.

- The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B at the time coverage begins and he/she has used MA plan 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 MA organization has not yet provided the ID cards).

40.4.2 - After the Effective Date of Coverage

The CMS recognizes that in some instances the MA organization will be unable to provide the materials and required notifications to new enrollees prior to the effective date, as required in §40.4.1. These cases will generally occur when an enrollment request is received late in a month with an effective date of the first of the next month. In these cases, the MA organization still must provide the member all materials described in §40.4.1 no later than 10 calendar days after receipt of the completed enrollment request. Additionally, the MA organization is also strongly encouraged to call these new members as soon as possible (such as within 1-3 calendar days) to provide the effective date, the information necessary to access benefits and to explain the MA organization rules. *The member's coverage will be active on the effective date regardless of whether or not the member has received all the information by the effective date.*

Acceptance/Rejection of Enrollment - Once the MA organization receives a *TRR* from CMS indicating whether the individual's enrollment has been accepted or rejected, the MA organization must notify the individual in writing of CMS' acceptance or rejection of the enrollment within ten calendar days of the availability of the weekly or monthly *TRR*, whichever contains the earliest notification of the acceptance or rejection (see Exhibits 6, 6a, 6c and 8 for model letters). 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. *These exceptions exist* so as not to penalize the *individual* for a systems issue or delay, such as a plan transmission or keying error. *In addition, this notice requirement does not apply to the scenario in which a transaction* rejection due to no Medicare Part A and/or no Medicare Part B *is received and* the MA organization has evidence to the contrary. In this case, the MA organization should not send a rejection notice and must request a retroactive enrollment from CMS (or its designee) within 45 days from the availability of the initial *TRR*. If CMS (or its designee) is unable to process the retroactive enrollment due to its determination that the individual does not have Medicare Part A and/or Part B, the MA organization must notify the individual of the rejection in writing within ten calendar days after CMS' (or its designee's) determination. Retroactive enrollments are covered in more detail in §60.4.

If an MA organization rejects an enrollment and later receives additional information from the individual showing entitlement to Medicare Part A and enrollment in Part B, the MA organization 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 §60.4 for more information regarding retroactive enrollments and the 45-day requirement.

40.5 - Enrollment Processing During Closed Periods

As described in §40.3, an MA organization must process elections in order by date of receipt of completed enrollment election when it is open for enrollment. However, an MA organization may close an MA plan during the OEP*, OEPI, or OEPNEW* (as described in §30) or when it reaches a CMS-approved capacity limit. This section addresses procedures for handling enrollments that arrive at the MA organization when an MA plan is closed for enrollment, and for processing those enrollments when the MA plan re-opens or a vacancy occurs.

If an MA organization believes its MA plan does not have the capacity to accept additional members, or as the MA plan enrollment grows and the MA organization estimates it may reach capacity during its next open enrollment period, the MA organization may request a CMS-approved limit on enrollment.

A capacity limit allows an MA organization to close or limit enrollment during the AEP, ICEP, and SEP. Only with a reserved vacancy may an MA organization set aside vacancies for enrollment of conversions. Refer to Chapter 1 (General Administration) of the Managed Care/Medicare Advantage Program for more detail on how and when to request a capacity limit.

40.5.1 - Procedures After Reaching Capacity

If the number of individuals who elect to enroll in an MA plan exceeds a CMS-approved capacity limit, then the MA organization may limit enrollment of these individuals, but only if it provides priority in acceptance.

If an MA organization receives completed enrollment *request*s between the time it reaches its limit and the time CMS approves the limit, it may follow one of two options **after it receives approval from CMS to limit enrollment:** (1) Deny the enrollment due to the onset of the capacity limit, or (2) Place the enrollment on a waiting list to be processed as vacancies occur in the priority of acceptance. This priority requires that the MA organization process enrollments from individuals who elected the MA plan prior to CMS' determination that the capacity has been exceeded, in order based on date of receipt of the completed enrollment *request*, and in a manner that does not discriminate on the basis of any factor related to health as described in 42 CFR §422.110.

The MA organization must take the same action for all enrollment *request*s received. See below for procedures for following options 1 or 2.

After the enrollments discussed in the above paragraph are acted upon, the MA organization has similar options for handling any additional enrollment requests received while the plan is closed for enrollment. The MA organization may follow one of two options: (1) Deny the enrollment due to the capacity limit, or (2) Place the enrollment on a waiting list to be processed when the plan re-opens for enrollment. However, to ensure no discrimination is applied to applications processed, all MA organizations that use option 1 (i.e., deny enrollment) for enrollments discussed in the above paragraph, must continue to deny all enrollments received while the plan is closed for enrollment, and may not use option 2. The MA organization must take the same action for all enrollment forms received. In the case of enrollments received after the plan closes for enrollment, the date the MA plan re-opens becomes the "receipt date" of enrollment forms received when the plan was closed.

> **EXAMPLE:** If the plan was closed in April and re-opens on May 1, then the receipt date of enrollment *request*s received in April is May 1. See below for procedures for following options 1 or 2.

If the MA Organization Uses Option 1 - It must notify the individual in writing that it is denying the enrollment, and should do so within ten calendar days after it receives the enrollment *request* or after the MA organization receives approval from CMS to limit enrollment (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

If the MA Organization Uses Option 2 - It must notify the individual in writing that he/she has been placed on a waiting list, and should do so within ten calendar days after the MA organization receives the enrollment *request* or after the MA organization receives approval from CMS to limit enrollment. The notice must also provide an estimated length of time that the individual will be on a waiting list and instruct the individual that he may cancel his enrollment before a vacancy occurs.

As enrollment spaces become available, if the plan was closed for more than 30 calendar days since the receipt of the enrollment form, the MA organization must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing

the enrollment. (The MA organization may make this contact even if the plan was closed for less than 30 days.) Within ten calendar days after contacting the individual, the MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc.

There may be situations in which the MA organization has closed enrollment in a service area, yet receives an approval for a capacity limit for a portion of that same service area. Given that MA plans are either open or closed for an ENTIRE service area, any vacancies which may open up may only be filled by individuals in their ICEP or SEP by applying the rules of accepting enrollments when MA plans are closed (see §40.5.2 below). Further, it must take those individuals based upon enrollments received in chronological order.

40.5.2 - Procedures After Closing During the OEP

As stated in §30, an MA organization must accept all *enrollment request*s for its MA plans made during the AEP, ICEP, or SEP. However, an MA organization may not process **OEP** enrollments for a plan when the plan is closed for enrollment during the OEP.

If an MA plan is closed during the OEP and receives new OEP enrollment forms or documentation to complete OEP enrollment forms already received by the MA organization, then the MA organization may do one of the following. The MA organization must take the same action for all enrollment forms received while the plan is closed:

1. Deny the enrollment;

2. Continue to accept the completed enrollment forms to be placed on a waiting list.

If the MA Organization uses option #1 above - It must notify the individual in writing that it is denying the enrollment, and should do so within ten calendar days after it receives the enrollment *request* (Exhibit 7). Please note that CMS encourages MA organizations to use this option if they expect that there will be no enrollment opportunities for longer than one month. This reduces the likelihood of multiple transactions and/or mistaken disenrollments that would occur if a potential applicant enrolls in another MA plan while waiting for the original MA plan to re-open.

If the MA Organization uses option #2 above - it must notify the individual in writing that he/she has been placed on a waiting list. The notice must inform the individual that the enrollment request will not be processed until the plan re-opens for enrollment, must include the date the plan will re-open, and must inform the individual that he/she may cancel the request for enrollment before the plan re-opens. All individuals who wish to wait for an opening must be placed on the waiting list.

After the MA plan re-opens, if the plan was closed for more than 30 calendar days since the MA organization received the enrollment *request*, it must contact (orally or in writing) the individual to re-affirm the individual's intent to enroll before processing the enrollment. (The MA organization may make this contact even if the plan was closed for less than 30 days.) The MA organization must send written notice of intent to not process the enrollment to all individuals who state they are no longer interested in being enrolled in the MA plan, and should do so within ten calendar days after contacting the individual.

For individuals who indicate their continued interest in enrollment, the MA organization must document the individual's expressed interest to continue enrollment. This may be done via phone contact report, notation on the enrollment form, etc. The date the MA plan re-opened becomes the "receipt date" of enrollment forms received when the plan was closed.

EXAMPLE

If the plan was closed in February and re-opens on March 1, then the receipt date of enrollment forms received in February is March 1.

40.6 - Enrollments Not Legally Valid

When an enrollment is not legally valid, a retroactive cancellation of enrollment action may be necessary (refer to §60.5 for more information on retroactive disenrollments). 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, as defined in §10, 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 an MA organization determines at a later date that the individual provided an incorrect permanent address at the time of enrollment and the actual address is outside the MA plan's service area. A second example could be an instance where an individual not authorized by State law to make an *enrollment request* on another's behalf attempts to complete an *enrollment request*.

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 member or his/her legal representative did not intend to enroll in the MA organization. If there is evidence that the individual did not intend to enroll in the MA organization, the MA organization should submit a retroactive disenrollment request to CMS. Evidence of lack of intent to enroll by the individual may include:

- An enrollment *request* signed by the individual when a legal representative should have signed for the individual;
- Request by the individual for cancellation of enrollment before the effective date (refer to §60.2 for procedures for processing cancellations);
- Enrolling in a supplemental insurance program immediately after enrolling in the MA organization; or

- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of coverage under the plan.

Payment of the premium does not necessarily indicate an informed decision to enroll. For example, the member may believe that he/she was purchasing a supplemental health insurance policy, as opposed to enrolling in an MA organization. In addition, use of an MA plan doctor does not necessarily indicate an understanding of the lock-in requirement if the doctor also treats non-plan members.

40.7 - Enrollment Procedures for Medicare MSA Plans

MA organizations offering a Medicare MSA plan must follow the procedures outlined in §§40.2, 40.3, 40.4, 40.5.1, and 40.6. MSA plans must have a paper enrollment form available for eligible individuals to request enrollment. Exhibit 1b is a model MSA plan enrollment form. Organizations may use this model form as it appears or may customize their enrollment forms based on this model, if they follow usual Medicare marketing material approval practices and ensure all the required MSA specific elements are included. Applications for Medicare MSAs must include a question regarding election of the Medicare hospice benefit.

All information necessary to successfully enroll the individual in the MSA plan must be provided to consider the enrollment request complete, including the answers to questions 1 – 4 on the model MSA enrollment form. Additionally, the organization must obtain the necessary banking and account information before the enrollment can be considered complete. The MA organization must ensure its materials describing the MSA plan explain the details of having the MSA account and what options the individual will have regarding the account.

Beneficiaries may enroll into a Medicare MSA plan only through the MA organization offering that plan. Beneficiaries may enroll directly with the plan by completing an approved paper enrollment form. Additionally, MSA plans may offer an online enrollment mechanism as defined in §40.1.2 through the organization's website. MSA plans are not available through the Online Enrollment Center on the Medicare.gov website.

Establishing the MSA Banking Account during the Enrollment Process

Medicare beneficiaries interested in enrolling in a MSA plan will need to establish an MSA bank account to accept MSA deposits in accordance with the MSA plan's procedures. The MA Organization must have documentation that a beneficiary will open the MSA account before submitting an enrollment transaction to MARx for that beneficiary. CMS will make the annual deposit payment to the plan on the same schedule as the monthly capitation payment. Per Section 1853(e)(2) of the Act, payment of an MSA deposit cannot be made until the beneficiary account has been established.

Acceptable documentation that an MSA account has been established includes a written/electronic notice from the bank that the beneficiary has opened an MSA account, or a written/electronic communication from the beneficiary that the MSA account has been opened, with the bank routing number and account number reported on the

communication. The MSA organization must retain this documentation. Described below are several procedures that the MSA Organization could implement to facilitate the establishment of these MSA accounts:

1. The organization provides the beneficiary with specific banking enrollment materials to begin the process necessary for establishment of the MSA banking account. The specified bank supplies the beneficiary with the required signature card and items needed for establishing the account. The beneficiary completes and returns the required documents to the specified bank. The bank provides the information to the MSA plan to complete the enrollment transaction.

2. For an employer/union sponsored MSA plan, the plan's designated bank deals directly with the employer or union allowing the employer or union to facilitate the establishment of an account on behalf of the Medicare beneficiaries enrolling in the MSA plan.

Finally, these procedures must accommodate the following guidance:

- MSA organizations must educate beneficiaries that the enrollment is not complete until the MSA account is set up.
- The organization must have documentation that the account has been established prior to submitting the enrollment transaction to CMS.
- *MSA organizations must educate beneficiaries that o*nce the enrollee's initial deposit has been received in the MSA account the enrollee may then transfer the funds to his or her own banking institution.

MARx will *not* reject an MSA enrollment transaction if CMS records show an open period of Medicaid or Hospice coverage*; however, MARx will provide information about these statuses*. MSA plans should contact the beneficiary to confirm *or deny* this information.

50 - Disenrollment Procedures

42 CFR 422.74

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

All notice requirements are summarized in Appendix 1.

50.1 - Voluntary Disenrollment by Member

A member may *request* disenroll*ment* from an MA plan only during one of the election periods outlined in §§30 and 30.7. As described in §30.3, MA organizations must deny OEP requests for voluntary disenrollment from MA-PD plans. 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 MA organization, or through his/her employer or union, where applicable;

3. Submitting a request via the Internet to the MA organization (if the MA organization offers such an option); or

4. Calling 1-800-MEDICARE.

If a member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above. The MA organization may send a disenrollment form to the member upon request (see Exhibits 9, *9a,* and 10).

The disenrollment request must be dated when it is initially received *by* the MA organization.

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 MA organization or CMS; and
3) Provide contact information.

50.1.1 – Requests Submitted via Internet

The MA organization has the option to allow members to submit disenrollment requests via the Internet; however, certain conditions must be met. The MA organization must, at a minimum, comply with the CMS security policies - found at http://*www*.cms.hhs.gov/*information*security/. However, the MA organization may also include additional security provisions. The CMS policies indicate that with regard to receiving such disenrollments via the Internet, an acceptable method of encryption must be utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

In addition, CMS policies also require MA organizations to provide the CMS Office of Information Services with a pro forma notice of intent to use the Internet for these purposes. The notice is essentially an attestation that the MA organization is complying with the required encryption, authentication, and identification requirements. The CMS reserves the right to audit the MA organization to ascertain whether it is in compliance with the security policy. The effective date of the request is determined by the election period in which the valid request was *received by the MA organization*. The election period is determined by the date the request is received *at* the site designated by the MA organization*, as described in member materials*.

50.1.2 - Request Signature and Date

When providing 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 §40.2.1 for more detail on who may sign *enrollment request* forms). If a legal representative signs the request for the individual, then he or she must attest to having the authority under State law to do so, and confirm that a copy of the proof of court-appointed legal guardian, durable power of attorney, or proof of other authorization required by State law that empowers the individual to effect an *enrollment request* on behalf of the applicant is available and can be presented upon request to the MA organization or CMS.

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 MA organization places on the request form will serve as the signature date.

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

50.1.3 - Effective Date *of Disenrollment*

The election period *during which the organization received a valid request to disenroll* will determine the effective date of the disenrollment; refer to §§30.6 and 30.7 for information regarding disenrollment effective dates.

With the exception of some SEPs and when election periods overlap, beneficiaries may not choose their effective date. Instead, the MA organization is responsible for assigning the appropriate effective date based on the election period. During face-to-face disenrollments, or when a beneficiary calls about a disenrollment, the MA organization staff are responsible for ensuring that a beneficiary does not choose an effective date that is not allowed under the requirements outlined in §§30.6 and 30.7.

If a beneficiary *submits* a disenrollment request with an unallowable effective date, or if the MA organization allowed the beneficiary to choose an unallowable effective date, the MA organization must call or write 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 call must be documented. If the beneficiary refuses to have the disenrollment processed with the correct effective date, the beneficiary can cancel the *enrollment request* according to the procedures outlined in §60.2.2.

50.1.4 - Notice Requirements

After the member submits a request, the MA organization must provide the member with a disenrollment notice within ten *(10)* calendar days of receipt of the request to disenroll. The disenrollment notice must include an explanation of the lock-in restrictions for the period during which the member remains enrolled in the organization, and the effective date of the disenrollment (see Exhibit 11). The MA organization may also advise the disenrolling member to hold Original Medicare claims for up to one month so that Medicare computer records can be updated to show that the person is no longer enrolled in the plan. For these types of disenrollments, i.e., disenrollments in which the member has disenrolled directly through the MA organization, MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment notice after receiving CMS confirmation of the disenrollment from the *TRR*.

Since Medicare beneficiaries have the option of disenrolling through sources other than the MA organization (such as 1-800-MEDICARE or by enrolling in another Medicare managed care plan or PDP), the MA organization will not always receive a request for disenrollment directly from the member and will instead learn of the disenrollment through the CMS *TRR*. If the MA organization learns of the voluntary disenrollment from the CMS *TRR* (as opposed to through written request from the member), the MA organization must send a written confirmation notice of the disenrollment to the member within ten calendar days of the availability of the *TRR* (see Exhibit 12).

For denials of voluntary disenrollment requests, the denial notice must be sent within 10 calendar days of the *date the disenrollment request was received* and must include the reason for denial (see Exhibit 12a).

50.1.5 - Optional Employer/Union MA Disenrollment *Request* Mechanism

As described in §20.4.1 of this chapter, beginning April 1, 2003, MA organizations that offer *employer or union group-sponsored* MA plans may choose to accept voluntary disenrollment *request*s *from beneficiaries enrolled in those plans* directly from the employer or union (or its TPA) without obtaining *a written disenrollment request* from each individual. *The disenrollment may only be prospective from the date the request is received by the employer/union group.*

- The MA organization must inform its Regional Office *Account Manager* of its intent to use this mechanism and identify the employer(s) or union(s) for which it will be accepting disenrollments made in this manner.

- The disenrollment information (i.e., the electronic file) submitted to the MA organization by the employer or union (or TPA) must accurately reflect the employer's or union's record of the disenrollment made by each individual according to the processes the employer or union has in place, and may be accepted without a paper MA *disenrollment request* form.

- This alternate *enrollment request* mechanism is used in place of paper MA *enrollment request* forms and does not require a signature. For purposes of compatibility with existing instructions in this chapter, the MA organization receipt date will be the date the employer's or union's record of an individual's disenrollment choice is received by the MA organization. MA organizations must record these dates.

- Effective date calculation of voluntary disenrollments and the collection and submission of disenrollments to CMS will follow existing procedures.

- To accept electronic records of employer or union *enrollment request*s, the MA organization must, at minimum, comply with the CMS security policies regarding the acceptable method of encryption utilized to provide for data security, confidentiality and integrity, and authentication and identification procedures to ensure both the sender and recipient of the data are known to each other and are authorized to receive and decrypt the information. (See the CMS Web site at: http://www.cms.hhs.gov/i*nformation*security for additional information.)

- The employer's or union's record of the *enrollment request* must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, the MA organization and/or CMS as necessary, and be maintained (by the employer/union or the MA organization, as they agree) for at least 6 years following the effective date of the individual's disenrollment from an MA plan. The MA organization must maintain its record of information received from the employer or union following the guidelines for MA *enrollment request* forms (see §60.9).

50.1.6 - Group Disenrollment for Employer/Union Sponsored Plans

CMS is providing a process for group disenrollment from an employer or union sponsored MA plan. CMS will allow an employer or union to disenroll its retirees from an employer or union sponsored MA plan 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 MA plan that the employer or union is offering; and
- This notice must be provided by either the MA organization, employer, or union not less than 21 calendar days prior to the effective date of the beneficiary's disenrollment from the employer/union sponsored MA plan.

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

The employer/union must have and provide all the information required for the MA organization to submit a complete disenrollment request transaction to CMS, as described in this and other CMS MA systems guidance. Records must be maintained as outlined in §60.9 of this chapter.

50.1.7 - Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll to Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and are eligible for such guaranteed issue rights. A beneficiary may contact you for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

50.2 - Required Involuntary Disenrollment

The MA organization **must** disenroll a member from an MA plan in the following cases. Refer to §50.6 for some exceptions to required disenrollment for grandfathered members.

1. A change in residence (for MA-PD plans, includes incarceration – *see below*) makes the individual ineligible to remain enrolled in the plan (§50.2.1)

2. The member loses entitlement to either Medicare Part A or Part B (§50.2.2.);

3. The member of a SNP that exclusively serves special needs individuals loses special needs status (§20.11) [NOTE: MA plans which were redesignated as SNPs that exclusively enroll special needs individuals may not involuntarily

disenroll members who, at the time of redesignation, were already enrolled in the plan.]

4. The member dies (§50.2.3); or

5. The MA organization contract is terminated, or the MA organization *reduces its service* area *to exclude the member*. There is an exception to this rule, which is described in §50.2.4.

Incarceration *– For MA-PD plans, a member who is incarcerated is considered to be residing outside the plan's service area, even if the correctional facility is located within the plan's service area. However, plans must disregard past periods of incarceration that have been served to completion if those periods have not already been addressed by a plan or by CMS (see §50.2.1.3 below).*

Notice Requirements - In situations where the MA organization disenrolls the member involuntarily on any basis except death or loss of entitlement, notices of the upcoming disenrollment meeting the following requirements must be sent. All disenrollment notices must:

1. Advise the member that the MA organization is planning to disenroll the member and why such action is occurring;

2. Be mailed to the member before submission of the disenrollment transaction to CMS; and

3. Include an explanation of the member's right to a hearing under the MA organization's grievance procedures. (This explanation is not required if the disenrollment is a result of the MA plan termination or service area or continuation area reduction, since a hearing would not be appropriate for that type of disenrollment. There are different notice requirements for terminations and *service* area reductions, which are provided in separate instructions to MA organizations.)

Medigap Guaranteed Issue Notification Requirements for Disenrollments to Original Medicare during a SEP

MA organizations are required to notify members of their Medigap guaranteed issue rights when members disenroll to Original Medicare during a SEP. Model language discussing these Medigap rights has been provided in Exhibit 11 and Exhibit 12.

There may be cases when a Medigap issuer requires the beneficiary to provide additional documentation that they disenrolled as a result of an SEP and are eligible for such guaranteed issue rights. A beneficiary may contact you for assistance in providing such documentation. The MA organization may provide such a notice to the beneficiary upon request (see Exhibit 24).

50.2.1 - Members Who Change Residence

MA organizations may offer (or continue to offer) extended "visitor" or "traveler" programs to members of coordinated care plans who have been out of the service area for up to 12 months. The MA organizations that offer such programs do not have to disenroll members in these extended programs who remain out of the service area for more than 6 months but less than 12 months. As mentioned at 42 CFR 422.74(d)(4)(iii), MA organizations offering a plan with a visitor/traveler program must make this option available to all enrollees who are absent for an extended period from the MA plan's service area. However, MA organizations may limit this option to enrollees who travel to certain areas, as defined by the MA organization, and who receive services from qualified providers. Organizations offering MA-PFFS plans may allow continued enrollment of individuals absent from the plan service area for up to 12 months, given that PFFS plans provide access to plan benefits and services from providers located outside the plan service area.

MA organizations *offering plans* without these programs must disenroll members who have been out of the *service* area for more than 6 months.

An SEP, as defined in §30.4.1, applies to individuals who are disenrolled due to a change in residence. An individual may choose another MA or Part D plan (either a PDP or MA-PD) during this SEP.

50.2.1.1 - General Rule

The MA organization must disenroll a member if:

1. He/she permanently moves out of the service area and his/her new residence is not in a continuation area;

2. The member's temporary absence from the service area (or continuation area, for continuation of enrollment members) exceeds 6 consecutive months;

3. The member is enrolled in an MA plan that offers a visitor/traveler program and his/her temporary absence exceeds 12 consecutive months (or the length of the visitor/traveler program if less than 12 months);

4. The member is an out-of-area member (as defined in §10), and permanently moves to an area that is not in the service area or continuation area;

5. He/she permanently moves out of the continuation area of an MA local plan and his/her new residence is not in the service area or another continuation area of the MA local plan;

6. The member permanently moves out of the service area (or continuation area, for continuation of enrollment members in MA local plans) and into a continuation area, but chooses not to continue enrollment in the MA local plan (refer to §60.7 for procedures for choosing the continuation of enrollment option);

7. The member is an out-of-area member (as defined in §10), who leaves his/her residence for more than 6 months;

8. The member is incarcerated (MA-PD plans only) and, therefore, out of area.

50.2.1.2 - Effective Date

Generally disenrollments for **reasons 1, 4, 5, 6 and 8** above are effective the first day of the calendar month after the date the member begins residing outside of the MA plan's service area (or continuation area, as appropriate) AND after the MA organization has been notified by the member or his/her legal representative. In the case of incarcerated individuals, MA organizations may receive notification of the individual's out-of-area status via a *TRR*. However, if the member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the 1st of the month after the move), the MA organization can submit this request to CMS *(or its designee)* for consideration of retroactive action.

Disenrollment for **reasons 2 and 7** above is effective the first day of the calendar month after 6 months have passed. Disenrollment for **reason 3** is effective the 1st day of the 13th month (or the length of the visitor/traveler program if less than 12 months) after the individual left the service area.

Unless the member elects another Medicare managed care plan during an applicable election period, any disenrollment processed under these provisions will result in a change to *enrollment in* Original Medicare.

50.2.1.3 - Researching and Acting on a Change of Address

When MA organizations receive a notice of a change of address *or an indication of possible out-of-area residency* from the member, the member's legal representative, a CMS *TRR*, or another source *t*he MA organization must make an attempt to contact the member to confirm whether the move is permanent*. The MA organization must also* document its efforts. In the case of incarcerated individuals, the MA organization is not required to contact the individual but must confirm the individual's out-of-area (e.g. incarcerated) status. MA organizations may obtain either written or verbal verification of changes in address, as long as the MA organization applies the policy consistently among all members. *When an organization is notified of a current member's past period of incarceration and has confirmed that this member's period of incarceration has ended (i.e. individual is no longer incarcerated), the organization must continue the individual's enrollment, unless otherwise directed by CMS.*

The MA organization must retain documentation from the member or member's legal representative of the notice of the change in address, including the determination of whether the *member's out-of-area status* is temporary or permanent.

1. If the MA organization receives notice of a **permanent change** in address **from the member or the member's legal representative**, and *the new* address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), the MA organization must disenroll the member and

provide proper notification. The only exception is if the member has permanently moved into the continuation area and chosen the continuation of enrollment option (procedures for electing a continuation of enrollment option are outlined in §60.8).

2. If the MA organization receives notice *(or indication)* of a *potential change in* address **from a source other than the member or the member's legal representative**, and *the new* address is outside the MA plan's service area (or continuation area, for continuation of enrollment members), the MA organization may not assume the move is permanent until it has received confirmation from the member, the member's legal representative or, for incarcerated individuals, public sources (such as a state/federal government entity or other public records).

   The MA organization must initiate disenrollment when it verifies a move is permanent or when the member has been out of the service area (or continuation area, for continuation of enrollment members) for six months from the date the MA organization learned of the change in address.

   MA organizations may consider the six months to have begun on the date given by the beneficiary as the date that he/she will be leaving the service area. If the beneficiary did not inform the MA organization of when he/she left the service area, the MA organization can consider the six months to have begun on the date *it received information regarding the member's potential* change in address (e.g. *TRR, out-of-area claims*).

   If the member does not respond to the request for verification within the time frame given by the MA organization, the MA organization cannot assume the move is permanent and may not disenroll the member until six months have passed. The MA organization may continue its attempts to verify address information with the member.

3. **Temporary moves** - If the MA organization determines the change in address is temporary, the MA organization may not initiate disenrollment until six months have passed from the date the MA organization *received information regarding the member's potential* change in address (or from the date the member states that his*/her* address changed, if that date is earlier).

   If the MA organization offers a visitor/traveler program, the MA organization must initiate disenrollment if it learns that the individual continues to remain out of the *service* area during the 12 months (or the length of its visitor/traveler program if less than 12 months).

50.2.1.4 - 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 organization as undeliverable.

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

1. If the USPS returns mail with a new forwarding address, forward plan materials to the beneficiary and advise the plan member to change his or her address with the Social Security Administration.
2. If the organization receives documented proof of a beneficiary change that is outside of the plan service area or mail is returned without a forwarding address, follow the procedures *described in §50.2.1.3*.
3. If the organization receives claims for services from providers located outside the plan service area, the organization may choose to follow up with the provider to obtain the member's address.
4. If the organization is successful in locating the beneficiary, 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/.

An organization is expected to continue to mail beneficiary materials to the undeliverable address, as a forwarding address may become available at a later date, and is encouraged to continue its efforts, as discussed above, to attempt to locate the beneficiary using any available resources, including CMS systems, to identify new address information for the beneficiary.

50.2.1.*5* - Notice Requirements

1. **MA organization notified of out-of-area permanent move** - When the organization receives notice of a permanent change in address from the member or the member's legal representative, it must provide notification of disenrollment to the member. This notice must be provided within 10 calendar days of the MA organization's learning of the permanent move.

    In the notice, the MA organization is encouraged to inform the member who moves out of the service area that he/she may have certain Medigap enrollment opportunities available to them. These opportunities end 63 days after coverage with the MA organization ends. The MA organization can direct the beneficiary to contact the State Health Insurance Assistance Program (SHIP) for additional information on Medigap insurance.

2. **Out of area for 6 months** - When the member has been out of the service area for 6 months after the date the MA organization learned of the change in address from a source other than the member or the member's legal representative (or the date the member stated that his address changed, if that date is earlier), the MA

organization must provide notification of the upcoming disenrollment to the member.

The notice of disenrollment must be provided *within the first ten calendar days of* the sixth month.

This notice must also be provided to out-of-area members (as defined in §10) who leave their residence for a location outside the service area, and that absence exceeds six months.

The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

EXAMPLE

MA organization receives a *TRR* on January 20 *indicating an* "out of area" *State and County Code.* The 6-month period ends on July 20. The MA organization sends a notice to the member *within 10 calendar days of receipt of the TRR* and does not receive any response from the member indicating this information is incorrect. Therefore, the MA organization will proceed with the disenrollment, effective August 1. *T*he MA organization sends a notice to the member *during the first 10 calendar days of* July notifying him that he will be disenrolled *effective August 1*.

3. **Visitor/Traveler Program Option -** When the member has been out of the service area for 12 months (or the length of its visitor/traveler program if less than 12 months), the MA organization must provide notification of the upcoming disenrollment to the member.

   The notice of disenrollment must be provided *during the first ten calendar days of* the 12th month (or the length of its visitor/traveler *program*).

   The CMS strongly encourages that MA organizations send a final confirmation of disenrollment notice to the member to ensure the individual does not continue to use MA organization services.

50.2.2 - Loss of Medicare Part A or Part B

With the exception of Medicare Part B-only grandfathered members (as described in §§20.6 and 50.6), the MA organization cannot retain a member in an MA plan if the member is no longer entitled to both Medicare Part A and Part B benefits. The organization will be notified by CMS that entitlement to either Medicare Part A 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 either Medicare Part A or Part B benefits (whichever occurred first).

If a member loses entitlement to Medicare Part A, the MA organization may not allow the member to remain a member of the plan and receive Medicare Part B-only services. In addition, the MA organization may not offer Part A-equivalent benefits and charge a

premium for such coverage to members who lose entitlement to Medicare Part A. Likewise, if a member loses entitlement to Medicare Part B at any time, the MA organization may not allow the member to remain in the MA plan.

Notice Requirements - CMS strongly suggests that notices be provided when the disenrollment is due to the loss of entitlement to either Medicare Part A or Part B (see Exhibit 14) so that any erroneous disenrollments can be corrected as soon as possible. In cases of erroneous disenrollment and notification, see §60.3.1.

50.2.3 - Death

The CMS will disenroll a member from an MA organization upon his/her death and CMS will notify the MA organization that the member has died. This disenrollment is effective the first day of the calendar month following the month of death. Organizations may not submit disenrollment transactions to CMS in response to the apparent death of a member. In anticipation of official notification from CMS via the TRR, organizations may, at their discretion, make note of the reported death in internal plan systems in order to suppress premium bills and member notices.

Notice Requirements – Following receipt of a CMS notification (via TRR) of disenrollment due to death, CMS strongly suggests that a notice 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, see §60.3.1.

50.2.4 - Terminations/Non-renewals

The MA organization must disenroll a member from an MA plan if the MA organization contract is terminated, or if the MA organization discontinues offering the plan or *reduces its service area to exclude the member.*

A member who is disenrolled under these provisions has an SEP, as described in §30.4.3, to elect a different MA plan or Original Medicare. A member who fails to make an *enrollment request* during this SEP is deemed to have elected Original Medicare.

EXCEPTION

MA organizations can offer an option to continue enrollment in an MA local plan in the organization to members affected by MA plan service area reductions in areas where no other MA plans are available at that time. If the organization chooses to offer this option, it must notify CMS, and must notify members in the beneficiary non-renewal notification letter.

Members must indicate their desire to take advantage of this option. Members who take this option to continue enrollment become known as “out-of-area members,” as defined in §10. The organization may require individuals who choose to continue enrollment in an MA local plan in the organization to agree to receive the full range of basic benefits (excluding emergency and urgently needed care, renal dialysis, and post stabilization)

exclusively at facilities designated by the MA organization within the MA local plan service area.

Notice Requirements - The MA organization must give each Medicare member a written notice of the effective date of the termination or service area or continuation area reduction, and include a description of alternatives for obtaining benefits under the Medicare program. Required time frames for these notices are outlined in 42 CFR 422.506 - 422.512.

50.2.5 – Loss of Special Needs Status

A SNP must continue to provide care for at least 30 days for a member who no longer has special needs status as long as the plan can provide appropriate care and the individual can reasonably be expected to again meet *the special needs* criteria within a 6-month period. For example, a dual eligible individual who loses Medicaid eligibility can be deemed to continue to be eligible for the plan if that individual would likely regain eligibility within six months. The SNP may choose any length of time from 30 days through 6 months for deeming continued eligibility as long as it applies the criteria consistently among all members of the plan and fully informs members of its policy. If the member of a SNP that exclusively enrolls special needs individuals does not re-qualify within this time period, s/he must be involuntarily disenrolled from the plan, with proper notice, at the end of this period. SNPs designated as "disproportionate share SNPs" must establish a similar period of deemed continued eligibility, as described above; however, individuals who do not re-qualify within this period are not involuntarily disenrolled. *The period of deemed continued eligibility begins the month following the month that Medicaid eligibility ends.*

During the deemed *continued* eligibility period the organization must continue to provide all plan benefits *and* must charge the deemed-eligible member the same *MA SNP plan* premium and cost sharing *charged to members who have not lost special needs status. Also, the organization* must continue coverage of any supplemental benefits (e.g., vision, dental, etc.) during *this period*.

If the SNP cannot provide continuity of care to a member who loses eligibility, the organization must involuntarily disenroll the member. For example, when a member of an institutional SNP leaves the long-term care facility, s/he must be disenrolled from that SNP if the SNP providers are limited to those within the facility. The organization must provide the beneficiary with a minimum of 30 days notice after the organization determines the member is no longer eligible.

Refer to Chapter 1 of the Medicare Managed Care Manual for additional information on Special Needs Plans.

Notice Requirements *- The SNP must provide each member a written notice regarding the loss of special needs status within 10 calendar days of learning of the loss of special needs status. This notice must provide the member an opportunity to prove that s/he is still eligible to be in the plan. In addition, the notice must include information regarding the period of deemed continued eligibility, including its duration, a complete description of the SEP for which such individuals are eligible (see §30.4.4, item #10), the consequences of not regaining special needs status within the period of deemed continued*

eligibility and the effective date of the potential consequences (exclusive SNP, see Exhibit 32).

In the event the individual fails to regain special needs status during the period of deemed continued eligibility, the SNP must provide the individual a written notice regarding involuntary disenrollment (exclusive SNP, see Exhibit 33) or the change in plan premium and/or cost sharing (disproportionate share SNP) within 10 calendar days of the expiration of the period of deemed continued eligibility.

In the case of a retroactive Medicaid termination, the SNP may not retroactively disenroll the individual. The SNP may disenroll the individual only after providing a minimum of 30 days' advance notice of the effective date of the involuntary disenrollment, including those instances in which the period of retroactivity exceeds the length of the SNP's period of deemed continued eligibility.

50.3 - Optional Involuntary Disenrollments

An MA organization may disenroll a member from an MA plan it offers if:

- Premiums are not paid on a timely basis (§50.3.1);
- The member engages in disruptive behavior (§50.3.2); or
- The member provides fraudulent information on an *enrollment request*, or if the member permits abuse of an enrollment card in the MA plan (§50.3.3).

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

- Advises the member that the MA organization 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 MA organization's grievance procedures.

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

50.3.1 - Failure to Pay Premiums

MA organizations may not disenroll a member who fails to pay MA plan cost sharing under this provision. However, an MA organization has three options when a member fails to pay the MA plan's basic and supplementary premiums.

For each of its MA plans (i.e. each PBP), the MA organization must take action consistently among all members of the discrete plan. For example, an MA organization

may have different policies among each of its plans, but it may not have different policies within a plan (other than the optional exception for dual-eligible individuals and individuals who qualify for the low income subsidy, as described below).

The MA organization **may**:

1. Do nothing, (i.e., allow the member to remain enrolled in the same premium plan);

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

3. If the member fails to pay the premium for optional supplemental benefits (that is, a package of benefits that the member is not required to accept), but pays the premium for basic and mandatory supplemental benefits, reduce the member's coverage (also known as "downgrade") by discontinuing the optional supplemental benefits and retaining the member in the **same** plan after proper notice. Given these requirements for a downgrade, this option clearly is only available for MA plans that have optional supplemental benefits offered at a higher premium than the basic benefit package. Such an action would be considered an addendum to the member's original *request to enroll* in the MA plan, and would not be considered a new *enrollment request*. Refer to Chapter 4 (Benefits and Beneficiary Protections) for a definition of "basic benefit," "mandatory supplement," and "optional supplemental benefits."

If the MA organization chooses to disenroll the member or reduce coverage, the action may only be accomplished after the MA organization has made a reasonable effort to collect the premium and notice has been provided (as described below). If payment has not been received within the grace period, the individual will be disenrolled (or coverage reduced, as applicable).

Organizations **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 organization receives a reply from CMS indicating that the member's request has been rejected. The organization 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.

Organizations 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 organization 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 organization must notify the member of the premium owed and provide the appropriate grace period, as described below. Organizations 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," if the member can demonstrate that Social Security Administration (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. Such a member **cannot** be disenrolled for failure to pay his/her premium(s), whether or not the organization actually receives these premiums on a timely basis.

> **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 an organization 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 SSA, or between CMS and the organization. CMS recognizes that in some instances organizations have not received premium amounts in their monthly CMS plan payment for members who have elected SSA withholding; however, organizations cannot hold their members responsible for such issues, nor penalize them by attempting to disenroll them from their plan. Therefore, the organization **may not** initiate the billing (and subsequent disenrollment process, if necessary) until a member is in "direct bill" status.

> **Example 2 – *Incorrect Data Due to Systems Miscommunication*:** 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 *premium* continues to be withheld.

In addition, organizations may not disenroll a member or initiate the disenrollment process if the organization has been notified that the Part D portion of the premiums are being paid by a SPAP, or other payer, and the organization has not yet coordinated receipt of the premium payments with the SPAP or other payer (refer to §50.6 of Chapter 14 of the Medicare Prescription Drug Benefit Manual for additional information regarding coordination of premium payments).

While the MA organization 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 or reduction in coverage is the first day of the month after the period ends. Unless the member elects another MA plan during an applicable election period, any disenrollment processed under these provisions will always result in a change of *enrollment request* to Original Medicare. **The MA organization 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 MA organization may require the individual to pay any outstanding premiums owed to the MA organization before considering the enrollment *request* to be "complete."

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

Calculating the Grace Period

An MA organization 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 whole number of months and cannot include fractions of months.* 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 providing an opportunity to pay. *For new enrollees of an MA-PD plan, the MA organization must wait until notified by CMS of the actual Part D 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 organization receives notification from CMS as to the beneficiary's premium and notifies the individual of the amount due. The grace period may begin no earlier than the first of the month for which the premium was unpaid.*

MA organizations 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 **- MA organizations 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 MA organization) are not paid in full by the end of the grace period, the MA organization may terminate or reduce the member's coverage.

As mentioned previously, the individual must be notified of/billed for 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 organization of the total premium due from the individual. Upon CMS notification, the organization would notify the individual of the amount due, with a prospective due date.

Under this scenario, MA organizations 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, 2005. He did not pay this premium and on February 7th, the MA organization 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, 2005.

Example B: Plan QRS has a 2-month grace period for premium payment. Plan member Mrs. Monsoon's premium was due on July 1, 2005. She did not pay this premium and on July 6th, the MA organization 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, 2005.

In short, the MA organization may require that the member pay the overdue premiums in full within the grace period, as well as all other payments becoming due within that period, in order to avoid disenrollment (or a reduction in coverage, where applicable). If the MA organization requires the member to make full payment within the grace period and pay all premiums falling due within that period; however, the MA organization must state so in its initial delinquency notice to the member.

Option 2 **- MA organizations 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 MA organization would then send another notice informing the member of any *delinquent premiums*. The member would then have a new grace period beginning on the 1st day of the next month for which the premium is unpaid. (The subsequent notice also would have to be sent within 10 calendar days (or 15 calendar days, as described below) of the date the subsequent premiums became delinquent and the notice would have to comply with the requirements for such notices, as discussed below.) This process would continue until the member's balance for *delinquent* premiums was paid in full or until the grace period expired with no premium payments being made, at which time the MA organization 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 plan premiums and has chosen the "rollover" approach to calculating the grace period. A member fails to pay his January premium due January 1. The MA organization 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 MA organization 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 MA organization 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 MA plan remains intact.

Notice Requirements - If *it is* the MA organization*'s policy* to disenroll the member or to reduce coverage when a member has not paid premiums, the MA organization must send an appropriate written notice (see Exhibit 19) to the member as follows:

- If the MA organization has a grace period of one calendar month, the organization must send a notice of non-payment of premium **within 10 calendar days** of the premium due date.

- If the MA organization has a grace period of two or more calendar months, the organization must send a notice of non-payment of premium **within 15 calendar days** of the premium due date.

The MA organization 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;

- 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 or reduction of MA coverage, whichever is appropriate according to the MA organization policy, and the proposed effective date of this action;

- Explain whether the MA organization 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 of membership or reduction in benefits; and,

- Explain the implications of a reduction in coverage (e.g., description of lower level of benefits), if the MA organization policy is to reduce coverage for the nonpayment of optional supplemental benefit premiums.

If a member does not pay within the grace period, and the MA organization's policy is to disenroll the member, the MA organization must notify the member in writing *providing* the effective date of the member's disenrollment (refer to Exhibit 20) *and submit a disenrollment transaction to CMS. The disenrollment notice to the individual and the transaction to CMS must be sent within 3 business days following the last day of the grace period; however, in no case may the disenrollment notice to the individual be sent after the transaction is submitted to CMS. In the event the organization submits a disenrollment request to CMS and later learns that payment was received timely, a reinstatement request must be submitted to CMS (or its designee).* In addition, CMS strongly encourages that MA organizations send final confirmation of disenrollment to the member after receiving the *TRR* (refer to Exhibit 21 for a model letter).

If a member does not pay within the grace period, and the MA organization policy is to reduce coverage *by eliminating optional supplemental benefits within the current plan,* for the nonpayment of optional supplemental benefit premiums, the MA organization must notify the member in writing *no later than 3 business days* after the expiration of the grace period that the MA organization is reducing the coverage and provide the effective date of the change in benefits (refer to Exhibit 22 for a model letter).

Optional Exception for Dual-Eligible Individuals and Individuals who Qualify for the Low Income Subsidy

MA organizations offering MA-PD plans have the **option** to retain dually eligible members and individuals who qualify for the low income subsidy (LIS) who fail to pay premiums even if the MA organization has a policy to disenroll members for non-payment of premiums. For MA-only plans, organizations may retain individuals who are dually eligible for both Medicare and Medicaid (i.e. individuals who are entitled to Medicare Part A and Part B and receive any type of assistance from the Title XIX (Medicaid) program).

The MA organization has the discretion to offer this option to dually eligible individuals and individuals who qualify for LIS within each of its MA plans. If the MA organization offers this option in one of its plans, it must apply the policy to all such individuals in that MA plan.

The policy to retain individuals is based upon non-payment of premium for the standard benefit package of the MA plan. If the MA organization chooses this option, any dually eligible individual or individual who qualifies for LIS who fails to pay premiums for any optional supplemental benefit offered would be downgraded to the standard benefit package within that MA plan.

Members of an MA plan must be informed at least 30 days before a policy changes within the plan. MA organizations 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. The CMS recommends a general statement in such notifications to avoid confusing other members for whom the policy does not apply.

> **Example:** "If you have Medicaid or receive 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.

50.3.2 - Disruptive Behavior

The MA organization **may** disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the MA plan substantially impairs the MA organization's ability to arrange for or provide services to either that particular member or other members of the plan. However, the MA organization may disenroll a member for disruptive behavior *only* after it has met the requirements of this section and with CMS' approval. The MA organization may not disenroll a member because he/she exercises the option to make treatment decisions with which the MA organization disagrees, including

the option of no treatment and/or no diagnostic testing. The MA organization may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the MA organization or any health care professionals associated with the MA organization.

Before requesting CMS' approval of disenrollment for disruptive behavior, the MA organization 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 MA organization must also inform the individual of his or her right to use the organization's grievance procedures.

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

- Of the disruptive behavior;
- Of the MA organization's serious efforts to resolve the problem with the individual;
- Of the MA organization'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 422.74(d)(2)(iii) and (iv);
- That the MA organization provided the member with appropriate written notice of the consequences of continued disruptive behavior (see Notice Requirements); and
- That the MA organization then provided written notice of its intent to request involuntary disenrollment (see Notice Requirements).

The MA organization 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 MA organization's ability to arrange for or provide services to the individual or other members of the MA plan;
- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;

- Statements from providers describing their experiences with the member; and

- Any information provided by the member.

- The MA organization may request that CMS consider prohibiting re-enrollment in the MA plan (or plans) offered by the MA organization in the service area.

The MA organization'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. The CMS will notify the MA organization 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. Any disenrollment processed under these provisions will always result in a change of *enrollment request* to Original Medicare.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the MA organization 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 MA organization to delay the effective date of involuntary disenrollment to coordinate with an MA *enrollment request* or Part D 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 MA organization's request.

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the MA organization 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 MA organization 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 MA organization must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the MA organization's efforts, then the MA organization 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. Refer to Chapter 13, "Grievances, Organizations Determinations, and Appeals," for the appropriate procedures for grievances. The MA organization 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 an MA organization to disenroll a member for disruptive behavior, the MA organization must provide the member with a written notice that contains, in addition to the notice requirements outlined in §50.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior described above. The MA organization may only provide the member with this required notice after CMS notifies the MA organization of its approval of the request.

The MA organization 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 MA organization gives the member a written notice of the disenrollment, or as provided by CMS.

50.3.3 - Fraud and Abuse

An MA organization **may** *request to* disenroll a member who knowingly provides, on the *enrollment request* form or by another *enrollment request* mechanism, fraudulent information that materially affects the determination of an individual's eligibility to enroll in the plan. The organization may also *request to* 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 organization gives the member the written notice.

When such a disenrollment occurs, the organization must immediately notify the CMS RO so the Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse. Any disenrollment processed under these provisions will always result in a change of *enrollment* to Original Medicare.

Notice Requirements - The MA organization must give the member a written notice of the disenrollment that contains the information required at §50.3.

50.4 - Processing Disenrollments

50.4.1 - Voluntary Disenrollments

After receipt of a completed disenrollment request from a member, the MA organization is responsible for submitting *the* disenrollment transaction to CMS in a timely, accurate fashion. For disenrollments effective December 31, 2007, or later, such transmissions must occur within 7 calendar days of receipt of the completed disenrollment request, in order to ensure the correct effective date.

The MA organization must maintain a system for receiving, controlling, and processing voluntary disenrollments from the MA organization. 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 MA organization) to establish the date of receipt;

- Dating supporting documents for disenrollment requests as of the date they are received;

- 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 *or union* (whichever applies). If the disenrollment information is received through the employer *or union*, the MA organization must obtain the member's written *disenrollment* request from the employer or union;

- For disenrollment requests received by the MA organization, notifying the member in writing within ten 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 11 for a model letter). MA organizations are encouraged, but not required, to follow up with a confirmation of disenrollment letter after receiving CMS confirmation of the disenrollment from the *TRR*;

- For all other voluntary disenrollments (i.e., voluntary disenrollments made by the beneficiary through 1-800-MEDICARE, or by enrolling in another MA plan or PDP, which the MA organization would not learn of until receiving the *TRR*), and notifying the member in writing to confirm the effective date of disenrollment within ten calendar days of the availability of the *TRR* (see Exhibit 12 for a model letter).

50.4.2 – When the Disenrollment Request is Incomplete

When the disenrollment request is incomplete, the MA organization 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 MA organization may verify with the individual with a phone call and document the contact, rather than return the written request as incomplete.

For AEP enrollment requests, 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 disenrollment request was initially received, or within 21 calendar days (whichever is later).

50.4.3 - Involuntary Disenrollments

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

The MA organization must maintain a system for controlling and processing involuntary disenrollments from the MA organization. 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 Medicare Parts A and/or B, notifying the member in writing of the upcoming involuntary disenrollment, including providing information on grievances rights.

In addition, CMS strongly encourages MA organizations to send confirmation of involuntary disenrollment to ensure the member discontinues use of MA organization services after the disenrollment date.

50.5 - Disenrollments Not Legally Valid

When a disenrollment is not legally valid, a reinstatement action may be necessary (refer to §60.3 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 §50.3) are considered legal and valid disenrollments, individuals would not qualify for reinstatements in these cases.

A voluntary disenrollment that is not complete, as defined in §10, 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.

The 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 MA organization. If there is evidence that the member did not intend to disenroll from the MA organization, the MA organization 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 §60.2 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 MA organization, 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.

50.6 - Disenrollment of Grandfathered Members

As discussed in §20.6, any individual who was enrolled in a §1876 risk plan effective December 1, 1998, or earlier, and remained enrolled with the risk plan on December 31, 1998, automatically continued to be enrolled in the MA organization on January 1, 1999, even if he/she was not entitled to Medicare Part A or did not live in an MA plan service area or MA organization continuation area.

Disenrollment procedures for grandfathered members are generally the same as those for other members. The MA organization must disenroll any grandfathered member if:

- The member dies;

- The member loses either Medicare Part A or Part B (or for Part B only members, enrollment in Medicare Part B ends for the member);

- The member permanently moves into the continuation area, but does not choose to continue enrollment or moves to an area that is out of the service or continuation area;

- The member permanently moves out of the vicinity making continued enrollment no longer reasonable. For example, a move of only a short distance may not affect the member's ability to continue to access the plan therefore continued enrollment would be reasonable.

- The MA organization contract is terminated, or if the service area or continuation area is reduced with respect to all MA individuals who live in the area where the individual resides;

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NOTE: The member may be offered the option to continue enrollment, as described in §50.2.4.

50.7 - Disenrollment Procedures for Employer/Union Sponsored Coverage Terminations

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

For both of the following options, the MA organization must ensure that the employer or union agrees to the following:

- The employer or union will provide the MA organization with timely notice of contract termination or the ineligibility of an individual to participate in the employer or union group sponsored MA plan. Such notice must be prospective, not retroactive.

- The employer or 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 or union.

Option 1: Enroll the individual(s) in another MA plan (i.e. individual plan) offered by the same MA organization unless the beneficiary makes another choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area. The individual plan selected for this option must be the same type of plan. For example, if the employer/union sponsored plan was an MA-PD coordinated care plan, the individual plan in this option must be an MA-PD coordinated care plan.

- Beneficiaries may elect another MA plan offered by the employer or union, join Original Medicare or join another MA plan as an individual member instead of electing the new MA plan offered by the employer or union.

    - If the beneficiary prefers not to be enrolled in the individual plan, s/he may contact the MA organization.

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

[1] The employer/union establishes criteria for its retirees to participate in the employer/union sponsored MA plan. These criteria are exclusive of and in addition to the eligibility criteria for MA 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 individual takes no other action, he/she will become a member of the individual plan offered by the same MA organization that offered the employer/union sponsored plan.

- **MA Notice requirements** -- The MA organization (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.

Option 2: Disenroll individual(s) from the employer/union sponsored MA plan to Original Medicare following prospective notice.

- **MA Notice requirements -** The MA organization (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 the employer/union sponsored plan was an MA-PD plan, the individual must be advised that the disenrollment action means 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 MA organization must outline in its written policies and procedures which of the above options it follows. It is the MA organization's responsibility to ensure that the process it has chosen is understood by the employer or union and is part of the agreement with each employer or union, including contract termination notification requirements.

50.8 - Disenrollment Procedures for Medicare MSA Plans

Members of Medicare MSA plans may only disenroll in writing through the MA organization offering the Medicare MSA plan; they may not disenroll through 1-800-MEDICARE. Election periods and effective dates for disenrollment from Medicare MSA plans are outlined in §30.7.

MA organizations offering Medicare MSA plans must otherwise follow the disenrollment policies and procedures outlined in §§50.2 through 50.5.

60 - Post-*Enrollment* Activities

42 CFR 60 & 422.66

Post-*enrollment* activities begin after the MA organization receives the *enrollment request* from the individual (e.g., cancellations), and last until a decision is made with respect to an individual's *enrollment request* (e.g., retroactive transactions).

60.1 - Multiple Transactions

Multiple transactions occur when CMS receives more than one *enrollment request* for the same individual with the same effective date in the same reporting period. An individual may generally not be enrolled in more than one MA, cost, HCPP or PDP plan 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).

Generally, the last *enrollment request* the beneficiary makes during an enrollment period will be accepted as the plan into which the individual intends to enroll. If an individual elects more than one plan 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 certain MA plan types and a separate PDP is permitted, CMS systems will accept both 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 the *enrollment request*s have the same application date.

EXAMPLES

- Two MA organizations receive enrollment forms from one individual. MAO #1 receives a form on March 4th and MAO #2 receives a form on March 10. Both organizations submit enrollment transactions, including the applicable effective date and application date. The enrollment in MAO #2 will be the transaction that is accepted and will be effective on April 1 because the application date on the enrollment transaction is the later of the 2 submitted. Both plans receive the appropriate reply on the *TRR*.

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

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

60.2 - Cancellations

Cancellations may be necessary in cases of mistaken enrollment made by an individual and/or mistaken disenrollment made by a member. Unless otherwise directed by CMS, an individual may cancel his/her enrollment only by contacting the organization prior to the effective date of the enrollment. For employer or union groups, cancellations properly made to the employer or union prior to the effective date of the *enrollment request* being canceled are also acceptable.

If a cancellation occurs after CMS records have changed, retroactive disenrollment and reinstatement actions may be necessary. Refer to §§60.3 and 60.5.

If a beneficiary verbally requests a cancellation, the MA organization should document the request. MA organizations have the right to request that a cancellation be in writing. However, they may not delay processing of a cancellation until the request is made in writing if they have already received *a* verbal *cancellation request* from the beneficiary.

For facilitated enrollment as described in §*40.1.5* of this chapter, a beneficiary may cancel the enrollment and affirmatively decline Part D benefits by telephone. The MA organization may not require these cancellations in writing.

60.2.1 - Cancellation of Enrollment

An individual's enrollment can be cancelled only 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 MA organization 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. In the event the MA organization has submitted the enrollment and is unable to submit a corresponding disenrollment transaction, or has other difficulty, the MA organization should contact CMS (or its designee) in order to cancel the enrollment.

When canceling an enrollment the MA organization must send a letter to the individual that states that the cancellation is being processed (see Exhibit 25). This notice should be sent within ten calendar days of the request. The language in the notice will depend upon whether the organization has already sent the enrollment transaction to CMS.

- If the enrollment transaction was not sent to CMS, then the notice must inform the member that the cancellation will result in the individual remaining enrolled in the health plan he/she originally was enrolled in.

- If the enrollment transaction was sent to CMS (in which CMS or its designee has been contacted to cancel the enrollment), then the notice must inform the member that if he/she was already enrolled in another MA plan, then the current enrollment action will have caused him/her to be disenrolled from the health plan he/she originally was enrolled in. The notice must also instruct the individual to contact the original MA organization if he/she wishes to remain a member of the MA plan in that MA organization.

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

If the member wants to return to Original Medicare, the member must be instructed to disenroll from the plan as described in §50.1 of this chapter. The member must be informed that the disenrollment must be made during an election period (described in §30.5) and will have a current effective date (as prescribed in §30.5), and must be instructed to continue to use plan services until the disenrollment goes into effect.

CANCELLATION OF MEDICARE MSA *ENROLLMENT REQUEST*:

An individual who elects a Medicare MSA plan during an AEP, and who has never before *enrolled in* a Medicare MSA plan, may revoke (i.e., "cancel") that *enrollment request*, but must do so by December 15 of the year in which *s/he enrolled in* the Medicare MSA plan. This cancellation will ensure the *enrollment request* does not go into effect on January 1.

60.2.2 - Cancellation of Disenrollment

A member's disenrollment can be canceled *only* if the request is made prior to the effective date of the disenrollment, unless otherwise directed by CMS.

To ensure the cancellation is honored, the MA organization 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 MA organization has submitted the disenrollment and is unable to submit the "canceling" enrollment transaction, or has other difficulty, the organization should contact CMS (or its designee) in order to cancel the disenrollment.

The MA organization must send a letter to the member that states that the cancellation is being processed and instructs the member to continue using MA plan services (see Exhibit 26). This notice should be sent within ten 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 §60.3.2. If a reinstatement will not be allowed, the MA organization should instruct the member to fill out and sign a

new enrollment form to re-enroll with the MA organization during an election period (described in §30), and with a current effective date, using the appropriate effective date as prescribed in §30.5.

60.3 - Reinstatements

Reinstatements may be necessary if a disenrollment is not legally valid (refer to §50.5 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, an organization may consult with CMS (or its designee) to reinstate members.

When a disenrolled member contacts the MA organization 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 MA plan, the MA organization must instruct the member in writing as soon as possible to continue to use MA plan services (refer to Exhibit 15, Exhibit 16, and Exhibit 17 for model letters). As of the effective date of enrollment, plan systems should indicate active membership.

A reinstatement is viewed as a correction necessary to "erase" an invalid disenrollment action and to ensure no gaps in coverage occur. Therefore, reinstatements may be made back to a date when an MA plan was closed for enrollment.

CMS (or its designee) will approve such reinstatements on a case-by-case basis.

60.3.1 - 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 membership. As outlined in 42 CFR 422.74(c), MA organizations have the option of sending notification of disenrollment due to death or loss of Part A or B. The CMS strongly suggests that MA organizations send these notices, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibit 13 and Exhibit 14 for model letters.

To request reinstatement for disenrollment due to erroneous death indicator or erroneous loss of Medicare Part A or Part B, the MA organization should submit the following information to CMS (or its designee):

- A copy of the *TRR* showing the disenrollment (include the system run date);

- A copy of any disenrollment letter that the MA plan may have sent to the individual (see §§50.2.2 and 50.2.3). Refer to model letters in Exhibits 13 and 14;

- 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 MA plan services 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 enrollment.

60.3.2 - Reinstatements Due to Mistaken Disenrollment Made By Member

As stated in §50.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, 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 §60.2.2), 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 a second MA organization, which resulted in an erroneous disenrollment from the original MA organization in which he/she was enrolled, and who was able to cancel the enrollment in the second MA organization (as outlined in §60.2.1). When a cancellation of enrollment in a second MA organization is properly made, the associated automatic disenrollment from the first MA organization becomes invalid. Generally, these reinstatements will be granted *only* when the member submits the request for reinstatement in writing in the time frames described in the next paragraph, and has used health care services from providers in the original (first) MA plan *only* (not including emergency or urgently needed services) since the original effective date of the disenrollment.

For reinstatement requests due to mistaken disenrollment by the member, when the disenrolled member verbally contacts the original MA organization to state that he/she mistakenly disenrolled, and states that he/she wants to remain a member of the MA plan, the MA organization must instruct the member to notify the MA organization in writing of the desire to remain enrolled in the plan within 30 calendar days after the MA organization sent the notice of disenrollment to the individual (*see* Exhibit 12). The MA organization must also instruct the member as soon as possible to continue to use MA plan services (*see* Exhibit 17). As of the effective date of enrollment, plan systems should indicate active membership.

If the MA organization 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 18), and should do so within ten calendar days after the date the member's written request was due at the MA organization.

To request reinstatement in response to a mistaken disenrollment by the member, the MA organization must submit the following information to CMS (or its designee):

- A copy of the *TRR* showing the disenrollment (include the system run date);
- A copy of the disenrollment letter sent to the individual. Refer to model letter in Exhibit 12 (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 MA 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 MA plan and has not used non-plan services (except for emergency or urgently needed services).

60.4 - Retroactive Enrollments

If an individual has fulfilled all enrollment requirements, but the MA organization or CMS is unable to process the enrollment for the required effective date (as outlined in §30.5), CMS (or its designee) will process a retroactive enrollment.

In addition, auto-enrollment for full-benefit dual eligible as described in §*40.1.5* 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 MA plan 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. Therefore, retroactive enrollments may NOT be made back to a date when an MA plan was closed for enrollment.

NOTE: Keep in mind that unless a capacity limit applies, all MA plans are open for ICEP, AEP, and SEP *enrollment request*s; therefore, all MA plans are open for retroactive enrollments for these types of *enrollment request*s.

Occasionally, obtaining the information necessary to complete an enrollment request within the allowable timeframes will extend beyond the CMS systems cut-off date for transaction submission, thus making the effective date of enrollment "retroactive" to the current payment month. In these cases, and only in these cases, MA organizations may utilize the Code 62 enrollment transaction to submit the enrollment transaction directly to CMS.

When an individual has fulfilled all enrollment requirements, but the organization or CMS is unable to process the enrollment, the 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 *TRRTRR*.

1. A copy of signed completed enrollment form (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 *enrollment request* record must show that the *enrollment request* was made prior to the requested effective date of coverage).

2. A copy of MA organization's letter to the member acknowledging receipt of the completed enrollment *request* and notifying the member to begin using the MA plan's services as of the effective date (refer to Exhibits 4, 4a, 4b and 4d for model letters). The letter must be dated prior to the requested retroactive effective date of coverage (or, when appropriate as outlined in §40.4.2, within ten calendar days after the effective date of coverage), in order to effectuate the requested effective date of coverage.

3. Evidence of Medicare Part A and Part B coverage, as described in §10.

4. Copies of at least one *TRRTRR* indicating the MA organization's attempts to submit valid enrollment transactions that were rejected. The effective date on the *TRR* must correspond with the requested effective date, in order to effectuate the retroactive effective date of coverage.

5. For cases of an erroneous indicator of ESRD, either because the individual has never had ESRD or because ESRD status has been terminated:

   - Evidence of contact with the individual after the first systems rejection, including the individual's explanation for rejection. If the individual reports that he/she no longer has ESRD or that he/she has had a kidney transplant or no longer receives dialysis services, then provide medical documentation, for example a letter from the physician or dialysis facility that documents date of transplant or last month of dialysis. If the individual reports that he/she never had ESRD, provide a statement signed by the individual (or his/her physician) to that effect.

- A copy of the *TRR*s or print screens indicating the MA organization's attempts to correctly enroll the individual and the resulting rejection. The effective date on the *TRR* must correspond with the requested effective date in order to effectuate the retroactive effective date.

In the event that CMS determines that the MA organization did not notify the member that he/she must use MA plan services during the period covered by the retroactive enrollment request, a retroactive enrollment request will be denied. In this case, if the Medicare eligible individual has used MA plan services during the period covering the retroactive enrollment request, the MA organization may bill Medicare for the services. The MA organization may bill for Medicare Part B services from the Medicare carrier but must have an indirect billing number to do so. Alternatively, the organization may have its certified MA plan providers bill for Medicare Part B services. Only the certified MA plan providers may bill the Medicare fiscal intermediary for Medicare Part A services. The beneficiary would be responsible for any co-insurance and deductible.

Special note regarding Regional Office Casework actions*: When an MA organization is directed by CMS, such as via an RO caseworker, to submit a retroactive enrollment or disenrollment request to resolve a complaint, the organization must provide the following 2 (two) items as documentation to CMS (or its designee):*

- *A screen print from the Complaint Tracking Module (CTM) or other documentation showing the CMS RO decision*
- *A copy of the enrollment or disenrollment request, if one is available. Occasionally, due to the nature of casework, this item may not be available. When that occurs, the organization should submit a brief statement of explanation for the missing documentation.*

For CTM cases only, no other documentation is required for submission to the CMS contractor.

60.5 - Retroactive Disenrollments

If an enrollment was never legally valid (§40.6) 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 (see §10 for a definition of "system error" and "plan error"), CMS (or its designee) may grant a retroactive disenrollment. CMS (or its designee) may also process a retroactive disenrollment if the reason for the disenrollment is related to a permanent move out of the plan service area (as outlined in §50.2.1.2), a contract violation (as outlined in 42 CFR 422.62(b)(3)) 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 an MA organization. Requests from an MA organization must include a copy of the disenrollment request, as well as an explanation as to why the disenrollment was not processed correctly. MA organizations must submit retroactive disenrollment requests to CMS (or its designee) as soon as possible. If CMS approves a request for retroactive disenrollment, the MA organization 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 MA organization (or by the member) to CMS (or its designee) in cases in which the MA organization has not properly processed or acted upon the member's request for disenrollment as required in §50.4.1 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 §30.6.

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

In some cases an MA organization that has both a Medicare contract and a contract with an EGHP arranges for the employer or union to process *enrollment request*s for Medicare-entitled group members who wish to make *enrollment request*s under the Medicare contract. However, there can be a delay between the time the member completes the *enrollment request* through the EGHP and when the *enrollment request* is received by the MA organization. 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 *request* within the timeframes described below, must be submitted to CMS (or its designee) for review. Repeated errors may indicate an ongoing problem and therefore will be forwarded to the MA organization's CMS *Account Manager* for compliance monitoring purposes. The MA organization'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 such errors.

60.6.1 - EGHP Retroactive Enrollments

The effective date of EGHP enrollment *request*s cannot be prior to the date the enrollment *request* was completed by the beneficiary. The effective date may be retroactive up to, but not exceeding, 90 days, from the date the organization 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*. *Enrollment request*s 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 request* were to be received by the MA organization 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.

NOTE: Keep in mind that unless a capacity limit applies, all MA plans are open for ICEP, AEP, and SEP *enrollment request*s. Therefore, all MA plans are open for retroactive enrollments for these types of *enrollment request*s.

No retroactive enrollments may be made unless the individual certifies that the MA organization (or EGHP) provided him/her with the explanation of enrollee rights (including the lock-in requirement) at the time of enrollment. The MA organization should submit such enrollments using Transaction Code 60. 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 MA organization.

60.6.2 - EGHP Retroactive Disenrollments

The MA organization must submit a retroactive disenrollment request to CMS (or its designee) if an EGHP does not provide the MA organization with timely notification of a member's requested disenrollment. Up to 90 day's retroactive **payment** adjustment is possible in such a case to conform to the adjustments in payment described under 42 CFR 422.250(b). The EGHP notification is considered untimely if it does not result in a disenrollment effective date as outlined in §30.6.

The MA organization must submit a disenrollment notice (i.e., documentation) to CMS (or its designee) demonstrating that the member acted to disenroll in a timely fashion (i.e., prospectively), but that the EGHP was late in providing the information to the MA organization. Such documentation may include an enrollment form for a new MA plan signed by the member and given to the EGHP during an open enrollment season. The documentation may not include a copy of a Medicare supplemental plan or Medigap plan enrollment form unless the member indicated on that form that he/she has canceled any other insurance. Such documentation should be sent to CMS (or its designee) as soon as possible.

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

Upon receipt of a CMS transaction reply, MA organizations must update their records to accurately reflect each individual's enrollment status. Organizations 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 MA organizations using the "700 series" TRCs that result from UI enrollment changes. In all cases, organizations 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. Organizations must determine the final disposition of the beneficiary to ensure the correct message is provided in any notice sent . In complex situations, CMS encourages organizations 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 *TRR*.

TRC	Beneficiary Communication Action
701 – New UI Enrollment	Organizations 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 Enrollment	Organizations must use **Exhibit 30,** "Enrollment Status Update." 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, organizations may use the existing cancellation of enrollment notice as provided in CMS enrollment guidance. If the specific situation warrants, organizations may use **Exhibit 30** 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, the organization 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), the organization must send the materials required in CMS enrollment guidance that would be provided for any new enrollment. Organizations must also send **Exhibit 30** describing the plan change, including the effective date. The impact of the change on plan premiums, cost sharing, and provider networks must be communicated clearly. 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 apply only 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, organizations should follow existing CMS enrollment guidance for providing notice and confirmation of the disenrollment. However, since many UI initiated changes are retroactive, organizations 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 organization 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, organizations may use existing confirmation of enrollment notices where there is confidence that such notice will not cause undue confusion. Alternatively, organizations may use **Exhibit 30**, including in it the new effective date and information about additional premium liability (ensure flexibility in allowing payment arrangements where necessary). Organizations 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. Organizations must use **Exhibit 30**. Organizations must explain the change in the effective date of coverage, and provide information on the refunding of any premiums paid. Organizations 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. Organizations must use **Exhibit 30**. Organizations must explain the change in the effective date of the end of coverage, and provide information on the refunding of any premiums paid. Organizations 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. Organizations must use **Exhibit 30**. Organizations 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. Organizations 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). Organizations must use **Exhibit 30** to explain the change and that enrollment in the plan is now continuous. Organizations 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.

60.8 - Election of the Continuation of Enrollment Option for MA Local Plans

When a member permanently moves into the MA organization's continuation area, the member must make a positive choice to continue enrollment in the MA local plan. The member does not have to complete and sign a new enrollment form in order for the

continuation to occur but must make this choice in a manner described in the MA organization's policy and procedure documents.

The MA organization must verify that the member has established permanent residence in the continuation area. Proof of permanent residence is normally established by the address of the residence, but the MA organization may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual.

The effective date of a continuation of enrollment change generally is the first day of the month after the individual moves into the continuation area.

60.9 - Storage of Enrollment and Disenrollment Records

As stated at 42 CFR 422.60(c)(2), MA organizations are required to file and retain *enrollment request* forms. MA organizations must retain and have available for evaluation enrollment and disenrollment records for the current contract period and ten (10) prior periods (42 CFR 422.504(e)(4)).

It is appropriate to allow for storage on microfilm, as long as microfilm versions of enrollment forms and disenrollment requests showing the signature and the date are available to reviewers. Similarly, other technologies that would allow the reviewer to access signed forms and other enrollment *request*s may also be allowed, such as optically scanned forms stored on disk.

Records of MA enrollment and disenrollment *request*s made by any other *enrollment request* mechanism (as described in §40.1) must also be retained as above.

Appendices

Summary of Medicare Advantage Notice and Data Element Requirements

Appendix 1: Summary of Notice Requirements

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

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

Notice	Section	Required?	Timeframe
Model Enrollment Form (Exh. 1)	10, 40.1.*1*, 40.2, 40.4.1	Yes[2]	NA
Information to include on or with Enrollment Form -- Information to Determine Enrollment Periods (Exh. 1a)	*30.4*	No	NA
MA MSA Enrollment Form (Exh 1b)	40.1.1	Yes[3]	NA
MA PFFS Enrollment Form (Exh 1c)	*40.1.1*	*Yes[4]*	*NA*
EGHP Enrollment Form (Exh. 2)	10, 40.1.*1*, 40.2, 40.4.1	No	NA
Short Enrollment Forms (Exh. 3 and 3a)	10, 40.1.*1*, 40.2, 40.4.1	No	NA
Acknowledgment of Receipt of Completed Enrollment *Request* (Exh. 4 and 4a)	40.4.1, 60.4	Yes[5]	10 calendar days of receipt of completed enrollment *request*
Combination Acknowledgement and Confirmation Notice (Exh. 4b)	40.4	Yes[6]	7 calendar days of *availability of the TRR*
Acknowledge Receipt of Completed PFFS Enrollment *Request* (Exh.4d)	40.4.1, 60.4	Yes[8]	10 calendar days of receipt of completed enrollment request
Request for Information (Exh. 5)	40.2.2	No	10 calendar days of receipt of enrollment request
Confirmation of Enrollment (Exh. 6	40.4.2,	Yes[9]	10 calendar days of

[2] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[3] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[4] *Other CMS approved enrollment election mechanisms may take the place of an enrollment form*
[5] Required unless combined acknowledgment/confirmation notice is issued.
[6] Required if the MAO has chosen to provide a single notice in response to the weekly TRR, as described in §40.4.1.
[8] Required unless combined acknowledgment/confirmation notice is issued.
[9] Required unless combined acknowledgment/confirmation notice is issued.

Notice	Section	Required?	Timeframe
and 6a)	40.6		*availability of TRR*
Notice to Individuals Identified on CMS Records As Members of Employer or Union Group Receiving Retiree Drug Subsidy (Exh. 6b)	40.2.5	Yes	10 calendar days of *availability of TRR*
Confirm PFFS Enrollment (Exh. 6c)	40.4.2	Yes[10]	10 calendar days of *availability of TRR*
MAO Denial of Enrollment (Exh. 7)	40.2.3	Yes	10 calendar days of *receipt of enrollment request OR expiration of time frame for requested additional information*
CMS Rejection of Enrollment (Exh. 8)	40.4.2	Yes	10 calendar days of *availability of TRR* (exception described in §40.4.2)
Sending Out Disenrollment Form/Disenrollment Form (Exh. 9*, 9a, &* 10)	50.1	No	NA
Acknowledgment of Receipt of Voluntary Disenrollment Request from Member (Exh. 11)	50.1, 50.4.1	Yes	10 calendar days of receipt of request to disenroll
Final Confirmation of Voluntary Disenrollment Request from Member (no exhibit)	50.1	No	NA
Confirmation of Voluntary Disenrollment Identified Through *TRR* (Exh. 12)	50.1, 50.4.1. 60.3.2	Yes	10 calendar days of *availability of TRR*
Denial of Disenrollment (Exh. 12a)	50.1.4	Yes	10 calendar days of *receipt of disenrollment request*
Rejection of Disenrollment (Exh. 12b)	50.1	Yes	10 calendar days of *availability of TRR*
Verification of Change in Address (no exhibit)	50.2.1	No	NA

[10] Required unless combined acknowledgment/confirmation notice is issued.

Notice	Section	Required?	Timeframe
Disenrollment Due to Permanent Move (no exhibit)	50.2.1	Yes	Within 10 calendar days of learning of the permanent move
Notice of Upcoming Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	Yes	*Within the first 10 calendar days of the 6th month*
Final Confirmation of Disenrollment Due to Out of Area > 6 Months (no exhibit)	50.2.1	No	NA
Disenrollment Due to Death (Exh. 13)	50.2.3, 50.4.2, 60.3.1	No	NA
Disenrollment Due to Loss of Part A and/or Part B Coverage (Exh. 14)	50.2.2, 50.4.2, 60.3.1	No	NA
Notices on Terminations/Non-renewals	50.2.4	Yes	Follow requirements in 42 CFR 422.506 - 422.512
Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit)	50.3.2	Yes	NA
Disenrollment for Disruptive Behavior (no exhibit)	50.3.2	Yes	Before the disenrollment transaction is submitted to CMS
Disenrollment for Fraud and Abuse (no exhibit)	50.3.3	Yes	Before the disenrollment transaction is submitted to CMS
Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15)	60.3, 60.3.1	Yes	10 calendar days of initial contact with member
Offering Beneficiary Services, Pending Correction of Erroneous Part A/B Termination (Exh. 16)	60.3, 60.3.1	Yes	10 calendar days of initial contact with member
Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Enrolling in Another MA organization (Exh. 17)	60.3, 60.3.2	Yes	10 calendar days of initial contact with member
Closing Out Request for Reinstatement (Exh. 18)	60.3.2	Yes	10 calendar days after information was due to MA organization
Failure to Pay Plan Premiums -	50.3.1	Yes	*Within 10 (or 15) calendar*

Notice	Section	Required?	Timeframe
Advanced Notification of Disenrollment or Reduction in Coverage (Exh. 19)			*days of the premium due date*
Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20)	50.3.1	Yes	*3 business days following the last day of the grace period*
Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21)	50.3.1	No	*NA*
Failure to Pay Plan Premiums - Notice of Reduction in Coverage (Exh. 22)	50.3.1	Yes	*10 calendar days of the expiration of the grace period*
Public Notices For Closing Enrollment due to Capacity Limit (Exh. 23)	40.5	Yes	15 days if related to CMS approved capacity limit
Notice that *Enrollment request* Placed on Waiting List (no exhibit)	40.5.1, 40.5.2	Yes	10 calendar days of receiving enrollment *request* or of approval from CMS to limit enrollment
Re-affirming Intent to Not Enroll (no exhibit)	40.5.1, 40.5.2	No	*10 days of contacting member*
Intent to Not Process Enrollment (no exhibit)	40.5.1, 40.5.2	Yes	10 calendar days of learning beneficiary no longer wants to enroll
Medigap Rights per Special Election Period (Exh. 24)	50.2, 50.1	No	Upon request.
Request to cancel enrollment (Exh. 25)	60.2.1	Yes	10 calendar days of request
Request to cancel disenrollment (Exh. 26)	60.2.2	Yes	10 calendar days of request
Inform Member of Auto-Enrollment (Exh. 27)	*40.1.5*	Yes	10 calendar days of identifying individual as needing auto-enrollment
Inform FBDE Member of Auto-Enrollment in PDP (Exh. 27a)	*40.1.5*	Yes	10 calendar days of identifying individual as needing auto-enrollment
Inform Member of Facilitated Enrollment (Exh. 28)	*40.1.5*	Yes	10 calendar days of identifying individual as needing *facilitated* enrollment

Notice	Section	Required?	Timeframe
Inform Member of Facilitated Enrollment into PDP (Exh. 28a)	*40.1.5*	Yes	10 calendar days of identifying individual as needing *facilitated* enrollment
Request to Decline Part D (Exh. 29)	*40.1.5*	Yes	10 calendar days of request
Enrollment Status Update (Exh. 30)	60.7	As necessary	10 calendar days of *availability of TRR*
Model Employer/Union Group Enrollment Mechanism Notice (Exh 31)	*40.1.6*	*Yes*	*21 calendar days prior to effective date of enrollment*
Loss of SNP Status (Exh 32)	*50.2.5*	*Yes*	*10 calendar days of loss of special needs status*
Loss of SNP Status - Notification of Involuntary Disenrollment (Exh 33)	*50.2.5*	*Yes*	*10 calendar days of expiration of period of deemed continued eligibility*

Appendix 2: *Summary of* Data Elements Required *for Plan Enrollment Mechanisms and* Complete*d* Enrollment *Requests*

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

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

Data Element		CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
1	MA Plan name	*Yes*	Yes	1, *1b, 1c,* 2, 3, 3a
2	MA Plan/Product/premium choice (if applicable)	*Yes*	Yes	1, *1b, 1c,* 2, 3a
3	Beneficiary name	*Yes*	Yes	1, *1b, 1c,* 2, 3, 3a
4	Beneficiary Date of Birth	*Yes*	Yes	1, *1b, 1c,* 2
5	Beneficiary Sex	*Yes*	Yes	1, *1b, 1c,* 2
6	Social Security Number (optional field)	*No*	No	1, *1b, 1c,* 2
7	Beneficiary Telephone Number	*Yes*	No	1, *1b, 1c,* 2, 3
8	Permanent Residence Address	*Yes*	Yes	1, *1b, 1c,* 2, 3
9	Mailing Address	*Yes*	No	1, *1b, 1c,* 2, 3
10	Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field)	*No*	No	1, *1b, 1c,* 2
11	E-mail Address (Optional Field)	*No*	No	1, *1b, 1c,* 2, 3
12	Beneficiary Medicare number	*Yes*	Yes	1, *1b, 1c,* 2, 3
13	Additional Medicare information contained on sample Medicare card, or copy of card	*No*	No	1, *1b, 1c,* 2
14	Plan Premium Payment Option	*Yes*[11]	No[12]	1, *1b, 1c,* 3, 3a
15	Response to ESRD Question	*Yes*	Yes	1, *1b, 1c,* 2
16	Response to long term care question	*No*	No	1, *1b, 1c,* 2

[11] *Zero premium MA-only plans omit this question*

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

	Data Element	CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
17	Response to other insurance COB information	*Yes*	No[13]	1, *1b, 1c,* 2
1*8*	Language preference *and alternative formats*	*Yes*	No	1, *1b, 1c,* 2, *and 3*
19	Annotation of whether beneficiary is retiree, including retirement date and name of retiree (if not the beneficiary)	*No*	No	2
20	Question of whether spouse or dependents are covered under the plan and, if applicable, name of spouse or dependents	*No*	No	2
21	Question of whether beneficiary is currently a member of the plan and if yes, request for plan identification number	*No*	No	2
22	Name of chosen Primary Care Physician, clinic or health center (Optional Field)	*No*	No	1, *1b, 1c,* 2, 3
23	Beneficiary signature and/or Authorized Representative Signature	*Yes*	Yes[14]	1, *1b, 1c,* 2, 3,3a
24	Date of signature	*Yes*	No[15]	1, *1b, 1c,* 2, 3, 3a
25	Authorized representative contact information	*Yes*	Yes	1, *1b, 1c,* 2,3, 3a
26	Employer or Union Name and Group Number	*Yes*	Yes	2
27	Question of which MA plan the beneficiary is currently a member of and to which MA plan the beneficiary is changing	*Yes*	Yes	3

[13] Refer to CMS COB guidance for additional information

[14] For Employer/Union Group MA enrollment elections as described in §*40.1.6*, and some other CMS approved enrollment elections, a signature is not required. For paper enrollment forms submitted without a signature, organization may verify with the applicant by telephone and document the contact instead of returning form.

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

	Data Element	CMS requires Field on enrollment mechanism?	Beneficiary response required on request?	Exhibit # in which data element appears
28	For enrollments into a Part D Payment Demonstration MA-PD plan, attestation regarding financial support for purchase of prescription drugs	*Yes*	Yes	1, *1b, 1c,* 3, 3a
29	For Special Needs Plans, verification of SNP eligibility	*Yes*	Y*es*	N/A
30	For MSA plans, *all additional elements including* proof that MSA bank account has been established	*Yes*	Yes	N/A
31	*Information provided under "please read and sign below"* *All elements provided in model language must be included on enrollment request mechanisms.* *Option -- can be provided as narrative or listed as statements of understanding*	*Yes*	*Yes*	*1, 1b, 1c, 2*
32	*Release of Information* *All elements provided in model language must be included on enrollment request mechanisms.*	*Yes*	*Yes*	*1, 1b, 1c, 2*

Appendix 3: Setting the Application Date on CMS Enrollment Transactions

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the beneficiary's choice of plan is honored. The application date is always a date prior to the effective date of enrollment.

Enrollment request Mechanism	*Application Date*	*Special Notes*
Paper Enrollment Forms *§40.1.1*	*The date the paper request is initially received*	*Paper requests submitted to or collected by sales agents or brokers are received by the MA organization on the date the agent or broker receives the form*
Enrollment forms received by Fax *§40.1.1*	*The date the fax is received on the MA organization's Fax machine*	
Medicare.gov Online Enrollment Center (OEC) *§40.1.3*	*The date "stamped" by CMS on the request*	
MA organization Web site online enrollment page *§40.1.3*	*The date the request is completed via the organization's website process*	
Approved Telephonic Enrollment ***§40.1.4***	*The date of the call*	
Seamless Conversion Option for Newly Eligible MA Members ***§40.1.5***	*First day of individual's Initial Coverage Election Period (ICEP)*	*Effective date must always be the date of the individual's first entitlement to* ***both*** *Medicare Part A and Part B*
Other Special Processes for Application Dates		
All enrollment requests into employer or union sponsored plans, regardless of mechanism used	*1st day of the month prior to the effective date of enrollment*	*This applies to all mechanisms including §§40.1.3 and 40.1.6*
Auto and Facilitated Enrollment *§40.1.5*	*The 1st of the month prior to the effective date of the auto/facilitated enrollment*	
SPAP enrollment requests as permitted in §40.1.8 made during the AEP	*November 15th of the current year*	*The effective date of enrollment is the following January 1st*
CMS required plan-submitted crosswalk (i.e. "rollover") transactions	*November 14th of the current year*	*The effective date of enrollment is the following January 1st. CMS approval is required as described in §10 of this guidance.*

EXHIBITS

Model Medicare Advantage Enrollment Forms & Notices

Exhibit 1: Model MA Individual Enrollment *Request* Form ("Election" may also be used)
Referenced in section(s): 10, 40.1, 40.2, 50.1

To Enroll in <plan>, 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:			
[*Optional field*: **Emergency contact:** _____ **Phone Number**:_____ **Relationship to You:** _____]			
[*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 and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

[***Zero premium MA-only plans may omit this section***: **Paying Your Plan Premium**

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

[MA-only and MA-PD plans with premiums insert: **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>

[Optional - Include other payment methods, such as EFT & credit card, as follows:
☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____
Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _
Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card: _____
Name of Account holder as it appears on card: _____
Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Expiration Date: _ _/_ _ _ _ (MM/YYYY)*]*

☐ Automatic deduction from your monthly *Social Security* benefit check. (The *Social Security* deduction may take two or more months to begin. In most cases, the first deduction from your *Social Security* benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

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

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

[MA-PD plans insert:

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

Will you have other prescription drug coverage in addition to <MA plan>? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage
_____	_____	_____*]*

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

If "yes" please provide the following information:

Name of Institution: _____

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

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

If yes, please provide your Medicaid number: _____

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

[Special Needs Plans insert question(s) regarding the required special needs criteria (i.e. "Do you live in a long term care facility" or "Do you have diabetes?"]

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

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

___ *<include list of available languages>*

___ *<include list of other formats*

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

***[Following box required only for MA-PD plans*:**

Please Read This Important Information

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

Please Read and Sign Below

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

<Plan Name> is a Medicare Advantage plan and *has a contract with the Federal government.* I will need to keep my Parts A and B. I can be in only one Medicare Advantage plan at a time *and I understand that my*

enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [***MA-only plans insert*:** I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. *Once I enroll,* I may leave this plan *or make changes* only at certain times of the year *when an enrollment period is available (Example: November 15 – December 31 of every year)*, or under certain special circumstances.

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date <plan name> coverage begins, I must get all of my health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. *[PPOs use the following in place of the first sentence: "I understand that beginning on the date <plan name> coverage begins, using services in-network can cost less than using services out-of-network, with the exception of emergency or urgently needed services or out-of-area dialysis services. If medically necessary, <plan> provides reimbursement for all covered benefits, even if received out of network."]* Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <PLAN NAME> WILL PAY FOR THE SERVICES.**

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

[***Insert the following for MA-PD Part D payment demonstration plan:*** By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of *medical services or medical coverage,* prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a *Medicare Advantage or* Medicare drug plan.]

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

I understand that my signature (or the signature of the person authorized to act on 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 <plan name> or by Medicare.

Signature:	**Today's Date:**

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

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

Office Use Only:
Name of staff member*/agent/broker* (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

[optional space for other administrative information needed by plan]

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

Referenced in section: 30.4

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. In addition, you can join a Medicare Advantage plan during the open enrollment period between January 1 and March 31 of each year, as long as you do not change your prescription drug coverage. *Additionally,* there are exceptions that may allow you to enroll in a Medicare Advantage plan outside of these periods.

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

- ☐ I am new to Medicare.
- ☐ I recently moved outside of the service area for my current plan.
- ☐ *I recently moved and this plan is a new option for me.*
- ☐ 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 *or recently 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 creditable prescription drug coverage (*coverage* as good as Medicare's).
- ☐ I am leaving employer or union 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.
- ☐ *None of these statements applies to me.**

**Please contact <plan name> at <phone number> (TTY users should call <TTY number>) to see if you are eligible to enroll. We are open <insert days and hours of operation>.*

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

Referenced in §40.1.1

To Enroll in <plan 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	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:			
[*Optional field:* **Emergency contact:** _____ **Phone Number**: _____**Relationship to You:** _____]			
[*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 and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

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

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Please read and answer these important questions

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

Generally, if you answered "yes" you are not eligible to enroll in <MSA plan name>. However, if you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

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

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

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

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

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

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

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____

3. Will you reside in the United States for at least 183 days during each year you are enrolled in <MSA plan>?

☐ Yes ☐ No

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

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

___ *<include list of available languages>*

___ *<include list of other formats (e.g. Braille, audio tape, or large print>*

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

Please Read and Sign Below:

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

<MSA Plan Name> is a Medicare Advantage plan and *has a contract with the Federal government.* I will need to keep my Parts A and B. I can be in only one Medicare Advantage plan at a time *and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan*. It is my responsibility to inform you of any health coverage that I have or may get in the future. I understand that if I do

not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. I may leave this plan ("disenroll") during the Annual Enrollment Period that is November 15th through December 31st of every year (disenrollment is effective the following January 1st) or under certain limited special circumstances, by sending a request in writing to <MSA plan name>. If I choose a Medicare MSA plan and have not ever before elected an MSA plan, then change my mind, I may cancel my enrollment by December 15 of the same year by contacting my plan to cancel my enrollment request. I understand that my enrollment into an MSA plan is not complete until the bank account is established. I understand that I am enrolling in a plan that does not pay for Medicare covered services until a high deductible is satisfied, but allows me to use funds in my MSA account to pay for health services. *Withdrawals made from the MSA bank account are not taxed when used for IRS qualified medical expenses. I would owe income tax and up to a 50% penalty for withdrawals used for non-medical expenses. A*fter the deductible is met the plan pays 100% of Medicare covered services.

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

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

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

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

I understand that if I disenroll before the end of the plan year (December 31st), <Company Name> may debit my MSA bank account for a prorated share of the current year's deposit to be returned to Medicare. The debit amount is based on the number of months remaining in the year following the disenrollment date. I understand that, in the even of my death, my estate will be responsible for any monies owed to Medicare. Any amounts in excess of the monies owed to Medicare are mine or my estate's to keep.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <MSA plan name> will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on 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 <MSA Plan Name> or by Medicare.

Signature:	**Today's Date:**

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

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

Office Use Only:
Name of staff member*/agent/broker* (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

[optional space for other administrative information needed by plan]

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

Referenced in section(s): 10, 20.4, 40.1, 40.2

To Enroll in <plan>, 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: ( ) [*Optional field*: Alternate 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:			
[*Optional field*: **Emergency contact:** _____ **Phone Number**:_____ **Relationship to You:** _____]			
[*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 and Part B to join a Medicare Advantage plan.

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex ___

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

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

[***Zero premium MA-only plans omit this section***:

Paying Your Plan Premium

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

[MA-only and MA-PD plans with premiums insert: **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>

[*Optional - Include other payment methods, such as EFT & credit card as follows:*
☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____
Bank routing number: _ _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _ _
Account type: ☐ Checking ☐ Saving

☐ Credit Card. Please provide the following information:

Type of Card: _____
Name of Account holder as it appears on card: _____
Account number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Expiration Date: _ _/_ _ _ _ (MM/YYYY)]

☐ Automatic deduction from your monthly Social Security benefit check. (The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please read and answer these important questions:

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

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

[*PFFS-PD plans insert:*
2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <PFFS plan>? ☐ Yes ☐ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Group # for this coverage
_____	_____	_____]

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

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

Physician Name: _____ Phone Number: _____]

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

Name: _____ City: _____ State: _____]

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

____ <include list of available languages>

____ <include list of other formats (e.g. Braille, audio tape, or large print)>

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

Please Read This Important Information

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

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

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

Please Read and Sign Below

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

<Plan Name> is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-For-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan [PFFS w/PD insert "or Medicare prescription drug plan."]. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [***PFFS w/o PD only plans insert*:** I understand that since this plan does not offer Medicare prescription drug coverage, I may obtain coverage from another Medicare prescription drug plan. If I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

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

Before seeing a provider, I should verify that the provider will accept <plan name>. I understand that my health care providers have the right to choose whether to accept a Private Fee-For-Service plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept <plan name>, I will need to find another provider that will.

<Plan name> serves a specific service area. If I move out of the area that <plan name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <plan name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I receive it to know which rules I must follow in order to receive coverage with this Private Fee-For-Service plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***Insert the following for PFFS-PD Part D payment demonstration plan:*** By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of medical services or medical coverage, prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a Medicare Advantage or Medicare drug plan.]

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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

from the plan.

I understand that my signature (or the signature of the person authorized to act on 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 <plan name> or by Medicare.

Signature:	**Today's Date:**

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

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

Office Use Only:
Name of staff member*/agent/broker* (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

[optional space for other administrative information needed by plan]

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

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

To Enroll in <plan name>, Please Provide the following Information:			
Employer or Union Name:		Group #:	
[*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:			
[*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 and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

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

If no, name of retiree: _____

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

If yes, name of spouse: _____

Name of dependents: _____

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

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

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

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

Will you have other prescription drug coverage in addition to <plan 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 Coverage: _____

6. 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):_____

[*Optional field:* **Please Choose a Primary Care Physician (PCP), clinic or health center:**]

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

___ *<include list of available languages>*

___ *<include list of other formats (e.g. Braille, audio tape, or large print)>*

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

Please Read and Sign Below

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

<Plan Name> is a Medicare Advantage plan and *has a contract with the Federal government.* I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time *and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan.* It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. [***MA-only***

***plans insert*:** I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.] Enrollment in this plan is generally for the entire year. *Once I enroll,* I may leave this plan *or make changes* only at certain times of the year *if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31)*, or under certain special circumstances.

<Plan Name> serves a specific service area. If I move out of the area that <Plan Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***MA PFFS do not include the following paragraph:*** I understand that beginning on the date <plan name> coverage begins, I must get all of my health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**]

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

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

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

I understand that my signature (or the signature of the person authorized to act on 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 <Plan Name> or by Medicare.

Signature:	**Today's Date:**
If you are the authorized representative, you must *sign above and* provide the following information: **Name :** _____	

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

Office Use Only:
Name of staff member*/agent/broker* (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

[optional space for other administrative information needed by plan]

Exhibit 3: Model Short Enrollment *Request* Form ("Election" may also be used)

This form may be used in place of the model individual enrollment form when a member of a MA plan is enrolling into another MA plan in the same MA organization. *This form is not applicable to MSA.*

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

Name of Plan You are Enrolling In: _____		
Name: _____	**Medicare Number:**_____ (Note: may use "member number" instead of "Medicare number")	
Home Phone Number:		
Permanent Street Address		
City:	State:	ZIP Code:
Mailing Address (only if different from your Permanent Street Address): Street Address: City: State: ZIP Code:		
Please fill out the following: I am currently a member of the _____ plan in _____<MAO name> with a monthly premium of $_____ . I would like to change to the _____ plan in _____ <MAO name>. I understand that this plan has different health benefits and a monthly premium of $____ .		
[*Optional Field:* **Name of chosen Primary Care Physician (PCP), clinic or health center:**]		
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in another format: ____ *<include list of available languages>* ____ *<include list of other formats (e.g. Braille, audio tape, or large print)>* *Please contact <plan name> at <phone number> (TTY users should call TTY number> if you need information in another format or language than what is listed above. Our office hours are <insert days and hours of operation>.*		

[Zero premium MA-only plans omit this section]

Your Plan Premium

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

[*MA-only and MA-PD plans with premiums insert****:*** **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 for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

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

Please select a premium payment option:

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

☐ Automatic deduction from your monthly *Social Security* benefit check. (The *Social Security* deduction may take two or more months to begin. In most cases, the first deduction from your *Social Security* benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please Read This Important Information

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

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

Please Read and Sign Below:

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

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

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information [***MA-PD plans insert:*** including my prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

[***MA PFFS do not include the following paragraph:*** I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**

[***Insert the following for MA-PD Part D payment demonstration plan:*** By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of *medical services or medical coverage,* prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a *Medicare Advantage or* Medicare drug 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 <Plan Name> or by Medicare.

Signature:	**Today's Date:**

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

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

Office Use Only:
Name of staff member*/agent/broker* (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

[optional space for other administrative information needed by plan]

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

This form is not applicable to MSA.

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

Dear <plan name> Member:

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

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

Please be aware that you can change health plans only at certain times during the year. Between November 15th and December 31st each year, anyone can join our plan. In addition, you can switch plans between January 1st and March 31st, as long as you do not change your prescription drug coverage. *Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area.*

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

If you select another plan and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will be <premium amount> and you may continue to see any <current plan name> primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

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

If you have any questions, please call *<plan name>* at <phone number - if plan is planning to have informational meetings - include information about time/place of meetings >. TTY users

should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. Thank you.

Plan Selection Form

Date:
Member Name:
Member Number:

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

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

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.>

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: visit copays, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc.>

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

[*Zero premium MA-only plans omit this section:*

Your Plan Premium

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

[MA-only and MA-PD plans with premiums insert: **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 for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

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

Please select a premium payment option:

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

☐ Automatic deduction from your monthly *Social Security* benefit check. (The *Social Security* deduction may take two or more months to begin. In most cases, the first deduction from your *Social Security* benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

[***Insert the following for MA-PD Part D payment demonstration plan:*** By joining this plan, I attest that I am not receiving any financial support from my current or former employer group or union (or my spouse's current or former employer group or union) intended for the purchase of *medical services or medical coverage,* prescription drugs or prescription drug coverage or to pay for, in whole or in part, my enrollment in a *Medicare Advantage or* Medicare drug plan.]

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

____ *<include list of available languages>*

____ *<include list of other formats (e.g. Braille, audio tape, or large print)>*

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

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

Please mail this form to:
<Insert mailing address>

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

Referenced in section(s): 40.4.1, 60.4

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

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for enrolling in <Plan name>. Beginning <effective date>, you must receive your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **[*Optional language*:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

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

[***MA plans without a premium – do not use the following two paragraphs:*** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. We will bill you for the portion of your monthly premium that you owe. You can pay by mail or by electronic Funds Transfer (EFT). <*Optional: insert other billing interval options, if available*>.

If you choose, you can have your monthly premium automatically deducted from your Social Security check. Generally you must stay with the option you choose for the rest of the year. If you are interested in this option, please contact us at <plan telephone number>. TTY users should call <TTY number>.]

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

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

Once enrolled in our plan, you can make changes *only* during certain times of the year. Between January and March, you have an opportunity to make one change, but you can only join a plan [*plans with drug benefit:* that has prescription drug coverage] [*plans without a drug benefit:* that does not have prescription drug coverage] Between November 15th and December 31st each year, anyone can make any type of change. *Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area.* If you have more questions about this, please feel free to call *<plan name>* at <phone number>.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

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

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

Referenced in section(s): 40.4.1, 60.4

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

Dear <Name of Member>:

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

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Beginning <effective date>, you must receive your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **<***Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>]

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

[***MA plans without a premium – do not use the following two paragraphs:*** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. We will bill you for the portion of your monthly premium that you owe. You can pay by mail or by electronic Funds Transfer (EFT). <*Optional: insert other billing interval options, if available*>.

If you choose, you can have your monthly premium automatically deducted from your Social Security check. Generally you must stay with the option you choose for the rest of the year. If you are interested in this option, please contact us at <plan telephone number>. TTY users should call <TTY number>.]

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

Once enrolled in our plan, you can make changes only during certain times of the year. Between January and March, you have an opportunity to make one change, but you can only join a plan [*plans with drug benefit:* that has prescription drug coverage] [*plans without a drug benefit:* that does not have prescription drug coverage] Between November 15th and December 31st each year anyone can make any type of change. *Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area.* If you have more questions about this, please feel free to call *<plan name>* at <phone number>.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

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

Referenced in section: 40.4, 60.4

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

Dear <Name of Member>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Therefore, beginning <effective date>, you must see your <plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, **or out-of-area dialysis services**, must be given or arranged by a <plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **<***Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>

[***MA PPO plans use the following paragraph in place of 1st paragraph above:*** Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Beginning <effective date>, you must receive your health care as provided in your <*insert either 'Member handbook' or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. **<***Optional language*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>]

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

If you think you qualify for extra help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.

[***MA-PD, if low-income subsidy applicable:*** Because you qualify for extra help with your prescription drug costs, you will pay *no more than*:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription.]

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

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

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

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

[***MA plans without a premium do not use the following paragraph:*** If you choose, you can have your monthly premium automatically deducted from your Social Security check. Generally you must stay with the option you choose for the rest of the year. If you are interested in this option, please contact *<plan name>* at *the phone number provided at the end of this letter*.

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

Once enrolled in our plan, you can make changes only during certain times of the year. Between January and March, you have an opportunity to make one change, but you can only join a plan [*plans with drug benefit:* that has prescription drug coverage] [*plans without a drug benefit:* that does not have prescription drug coverage]. Between November 15th and December 31st each year, anyone can make any type of change. If you have more questions about this, please feel free to call *<plan name>* at *the phone number provided at the end of this letter*.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a

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

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

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

Referenced in section(s): 40.4.1, 60.4

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

Dear <Name of Member>:

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

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

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

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

[***Optional*:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you

a letter to confirm your enrollment with <plan name>. But you should not wait to get this letter before you begin showing your <plan name> ID card (or this letter) to your doctors on <effective date>. Also, do not cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

[***MA plans without a premium – do not use the following two paragraphs:*** If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. We will bill you for the portion of your monthly premium that you owe. You can pay by mail or by Electronic Funds Transfer (EFT). *<Optional – insert other billing interval options, if available>*.

If you choose, you can have your monthly premium automatically deducted from your Social Security check. Generally you must stay with the option you choose for the rest of the year. If you are interested in this option, please contact *<plan name>* at *the phone number provided at the end of this letter*.]

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

Once enrolled in our plan, you can only make changes during certain times of the year. Between January and March, you have an opportunity to make one change, but you can only join a plan [*plans with drug benefit:* that has prescription drug coverage] [*plans without a drug benefit:* that does not have prescription drug coverage]. Between November 15th and December 31st each year, anyone can make any type of change. If you have more questions about this, please feel free to call *<plan name>* at *the phone number provided at the end of this letter*.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

Exhibit 5: Model Notice to Request Information

Referenced in section(s): 40.2.2

Dear <Name of Member>:

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

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

_____ Proof of Medicare Part A and B coverage. Please send us a copy of your Medicare ID card as proof of your Medicare coverage.

_____ Other: _____

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

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

Thank you.

Exhibit 6: Model Notice to Confirm Enrollment

Referenced in section(s): 40.40.2, 40.6

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

Dear <Name of Member>:

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

[***MA-PD, if no low-income subsidy:*** The monthly premium for your plan is: <premium amount>.

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

[***MA-PD, if low-income subsidy applicable:*** Because you qualify for extra help with your prescription drug costs, you will pay *no more than*:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription.]

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

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

[MA-only plans omit: If we determine that you owe a late enrollment penalty (or have a late enrollment penalty that needs to be adjusted), we will notify you of your new monthly premium amount.]

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

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

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

Thank you.

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

Referenced in section(s): 40.40.2, 40.6

Dear <Name of Member>:

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

[***MA-PD, if no low-income subsidy:*** The monthly premium for your plan is <premium amount>.

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

[***MA-PD, if low-income subsidy applicable:*** Because you qualify for extra help with your prescription drug costs, you will pay *no more than*:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription.]

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

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

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

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

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

Thank you.

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

Referenced in section(s): 40

Dear <Name of Member>:

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

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

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

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

If you have already discussed this decision with your benefits administrator and have decided that you would still like to be a member of <plan name>, **please confirm this by calling** *<plan name>* **at *the* phone number *provided below***. Your enrollment will not be complete until you call and confirm this information. Your effective date will be <effective date>.

We must hear from you to enroll you in our plan - if we 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 i*f you have any questions, please feel free to contact *<plan name>* at <*phone* number>. We are open <insert days/hours of operation and, if different, *TTY* hours of operation>.

Thank you.

Exhibit 6c: Model Notice to Confirm PFFS Enrollment

Referenced in section: 40.4.2

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

Dear <Name of Member>:

Thank you for enrolling in <Plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Beginning <effective date>, you will begin to receive your healthcare from <plan name>. You must show your <Plan name> ID card to your doctor or hospital before you receive healthcare. You may no longer use your red, white, and blue Medicare card to receive healthcare, because **Original Medicare will not pay for your healthcare while you are enrolled in this plan.** You should keep your Medicare card in a safe place. <*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>

<Plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. As we told you before, <Plan name> allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. You should contact your doctor *or hospital* to ask whether *they* will accept our plan's payment terms. *Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.*

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

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

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

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

[***MA-PD, if low-income subsidy applicable:*** Because you qualify for extra help with your prescription drug costs, you will pay *no more than*:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription.]

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

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

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

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

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

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

Thank you.

Exhibit 7: Model Notice for MA Organization Denial of Enrollment

Referenced in section(s): 40.2.3

Dear <Name of Beneficiary>:

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

1. _____ You do not have Medicare Part A.

2. _____ You do not have Medicare Part B.

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

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

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

6. _____ We did not receive the information we requested from you within the timeframe listed in our request.

[7. _____ [***MA-PD plans only:*** You are not eligible to enroll in prescription drug coverage at this time]

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

If item 5 *[MA-PD plans insert: or item 7]* is checked, remember that you can make changes only at certain times during the year. Between January and March, you have an opportunity to make one change, but you can only join a plan [*plans with drug benefit:* that has prescription drug coverage] [*plans without a drug benefit:* that does not have prescription drug coverage]. Between November 15th and December 31st each year anyone can make any type of change. *Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area.* If you have more questions about this, please feel free to call *<plan name>* at *the phone number provided below*.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

Exhibit 8: Model Notice for CMS Rejection of Enrollment

Referenced in section(s): 40.4.2

Dear <Name of Beneficiary>:

Medicare has denied your enrollment in <MA Plan> due to the reason(s) checked below:

1. _____ You do not have Medicare Part A
2. _____ You do not have Medicare Part B
3. _____ You have End Stage Renal Disease (ESRD)
4. _____ You attempted to enroll outside of an enrollment period.
5. _____ You requested to enroll in a different plan for the same effective date, which canceled your application with <plan name>.

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

If item 4 is checked, remember that you can make changes only at certain times during the year. Between January and March, you have an opportunity to make one change, but you can only join a plan [*plans with drug benefit:* that has prescription drug coverage] [*plans without a drug benefit:* that does not have prescription drug coverage]. Between November 15th and December 31st each year, anyone can make any type of change. *Generally, you may not make changes at other times unless you meet certain special exceptions.* If you have questions about this, please feel free to call *<plan name>* at *the phone number provided below*.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

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

Referenced in section(s): 50.1

Dear <Name of Member>:

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

When can individuals with Medicare make changes to their coverage?

You can make plan changes, such as requesting disenrollment, only at certain times during the year. Between November 15th and December 31st each year, anyone can make any type of change. Between January 1st and March 31st each year, you can make a change as long as you do not change your prescription drug coverage. *Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area.*

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

Information about the disenrollment request form

*You **should** fill out the attached form if you want to change to the Original Medicare plan only and do not want Medicare prescription drug coverage.*

*You **should not** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage or other Medicare Health Plan. Enrolling in another Medicare plan will automatically disenroll you from our plan.*

- *You **should not** fill out the attached form if you are enrolling in a Medicare prescription drug plan. Enrolling in a Medicare prescription drug plan will automatically disenroll you from <plan name> to Original Medicare.*

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

Submitting your Disenrollment Request

If you want to disenroll to the Original Medicare plan, *as described above,* you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can call 1-800-MEDICARE (1-800-633-4227) for information about Medicare plans available in your area. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

A NOTE ABOUT MEDIGAP RIGHTS

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap policies in your State. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

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

Thank you.

Attachment

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

Referenced in section(s): 50.1

Dear <Name of Member>:

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

When can individuals with Medicare make changes to their coverage?

You can make plan changes, such as requesting disenrollment, only at certain times during the year. Between November 15th and December 31st each year, anyone can make any type of change. Between January 1st and March 31st each year, you can make a change as long as you do not change your prescription drug coverage. Generally, you may not make changes at other times unless you meet certain special exceptions, such as if you move out of the plan's service area.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

Information about the disenrollment request form

*You **should** fill out the attached form if you want to change to the Original Medicare plan only and do not want Medicare prescription drug coverage.*

*You **should not** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Advantage or other Medicare Health Plan. Enrolling in another Medicare plan will automatically disenroll you from <plan name>.*

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

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

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

Submitting your Disenrollment Request

If you want to disenroll to the Original Medicare plan, as described above, you may fill out the attached form, sign it, and send it back to us in the enclosed envelope. You can also fax the form with a readable signature and date to us at <fax number>. You can call 1-800-MEDICARE (1-800-633-4227) for information about Medicare plans available in your area. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

INFORMATION ABOUT MEDIGAP RIGHTS

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. ***Your State may have laws that provide more Medigap protections.*** *If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap policies in your State. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.*

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

Thank you.

Attachment

Exhibit 10: Model Disenrollment Form

Referenced in section: 10

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

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

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

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

Your Signature*: _____ Date: _____

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

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

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

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

Referenced in section(s): 50.1, 50.1.4, 50.4.1

Dear <Name of Beneficiary>:

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

[***MA-PD plans insert:*** When coverage from <plan name> ends after <date>, your Medicare prescription drug coverage ends too. In order to have new health care coverage and prescription drug coverage after <date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action, as described in this letter. For example, if you are returning to Original Medicare coverage, to receive Medicare prescription drug coverage you must join a Medicare prescription drug plan. Please remember, if you disenroll and do not enroll in another Medicare Advantage Plan with prescription drug coverage (or Medicare Prescription Drug Plan) or if you do not obtain other creditable coverage as good as Medicare, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future. If you don't take any action, you will be covered by the Original Medicare Plan beginning <effective date>.]

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

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

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

A NOTE ABOUT MEDIGAP RIGHTS

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right.

Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap policies in your State. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

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

Exhibit 12: Model Notice to Confirm Voluntary Disenrollment Identified Through *TRR*

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

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <MA Plan>. Beginning <effective date,> <plan name> will not cover any health care you receive. If your doctor needs to send Medicare claims, you may want to tell them that there may be a short delay in updating your records since you *recently* disenrolled from <plan name>.

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

A NOTE ABOUT MEDIGAP RIGHTS

If you will be changing to the Original Medicare Plan you might have a special temporary right to buy a Medigap policy, also known as Medicare supplement insurance, even if you have health problems. For example, if you are age 65 or older and you enrolled in Medicare Part B within the past 6 months or if you move out of the service area, you may have this special right. Federal law requires the protections described above. **Your State may have laws that provide more Medigap protections.** If you have questions about Medigap or any special temporary rights you may have, you should contact your State Health Insurance Program <insert name of SHIP> at <SHIP phone number> to get more information about Medigap policies in your State. Call 1-800-MEDICARE (1-800-633-4227) for more information about trial periods. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

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

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

Referenced in section: 50.1.4

Dear <Name of Beneficiary>:

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

1. _____ You have attempted to make a change outside of an enrollment period.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

[***MA-PD plans only:***

3. _____ In order to disenroll from your current plan during the Open Enrollment Period (January through March) you must enroll in a Medicare prescription drug plan or enroll in another Medicare health plan that includes prescription drugs.]

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

- **From January 1 until March 31**, anyone with Medicare (including members of <plan Name>) has one opportunity to make a change in the way they get Medicare.

- **From November 15 to December 31,** anyone with Medicare can switch from one way of getting Medicare to another, including when you can enroll in Medicare prescription drug coverage.

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

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

Exhibit 12b: Model Notice for CMS Rejection of Disenrollment

Referenced in section: 50.1

Dear <Name of Beneficiary>:

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

1. _____ You have attempted to make a change outside of an enrollment period.

2. _____ You have already made a change to how you get Medicare (see discussion on limits to changes below.)

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

- **From January 1 until March 31**, anyone with Medicare (including members of <plan Name>) has one opportunity to make a change in the way they get Medicare.

- **From November 15 through December 31**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

Generally, you may not make any other changes during the year unless you meet certain special exceptions, such as if you move out of the plan's service area or if you *qualify for extra help with your prescription drug costs*.

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

Exhibit 13: Model Notice of Disenrollment Due to Death

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

To the Estate of <Member Name> (or To <Member Name>):

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

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

[*MSA plans insert the following*: Please note that the Estate will be liable to <MA organization> for a portion of the MSA deposit made by the MSA Plan at the time of enrollment. The amount owed is based on the number of months remaining in the year following the disenrollment date.]

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

Thank you.

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

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

Dear <Name of Member>:

Medicare has told us that you no longer have Medicare Part <insert A and/or B, as appropriate>. You need to have coverage under both Medicare Part A and Part B to remain enrolled in a Medicare Advantage plan. Therefore, your membership in <plan name> ended on <date>. If this information is wrong, and you want to stay a member of our plan, please contact us. Also, if you have not already done so, please contact your local Social Security office to have their records corrected.

[***MA-PD plans insert*:** When coverage from <plan name> ended on <date>, your Medicare prescription drug coverage ended too. If you still have either Medicare Part A or Medicare Part B you are eligible for Medicare prescription drug coverage. To receive Medicare prescription drug coverage, you must enroll in a Medicare prescription drug plan. If you are eligible to join a Medicare prescription drug plan but do not join, and you do not have other drug coverage that is at least as good as Medicare's, you may have to pay a late enrollment penalty if you join later. This means you pay a higher premium for as long as you have Medicare prescription drug coverage.]

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

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

Referenced in section(s): 60.3, 60.3.1

Dear< Name of Member>:

Medicare incorrectly shows you as deceased.

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

In the meantime, you should keep using your <plan name> primary care physician for your health care. **(Note: If PCP not applicable, omit this sentence. MA plans may insert "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate.)** If you have any questions or need help, please call us at < phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

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

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

Referenced in section(s): 60.3, 60.3.1

Dear < Name of Member>:

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

[Organizations that are able to verify current Medicare entitlement may omit the following:
To do this, please complete the following *three* steps *no later than <insert date: 60 days from date of disenrollment notice>*:

1. Contact Social Security at 1-800-772-1213 between 7AM to 7PM, Monday to Friday, to have them fix their records TTY users should call 1-800-325-0778.

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

3. Send the letter from *Social Security* to us at: <address of MA Plan> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we receive this letter, we will tell the Medicare to correct its records.

[Organizations that are able to verify current Medicare entitlement insert: We have confirmed that the error has been corrected. We will tell Medicare to correct its records.]

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

[Organizations that are able to verify current Medicare entitlement omit the following:
If we find out that you do not have Medicare Part <insert “A” and/or “B” as appropriate>, *or if we do not receive proof that you have Medicare by <insert date: 60 days from date of disenrollment notice>,* you will have to pay for any service you received after <disenrollment date>.

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

Thank you for your continued membership in <MA Plan>.

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

Referenced in section(s): 60.3, 60.3.2

Dear <Name of Member>:

Thank you for letting us know you want to remain a member of <plan 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 canceled your membership in the other plan and want to stay a member of <plan name>. Please send us a letter by <insert date: 30-days from date of disenrollment notice>, that says you want to stay a member of <plan name>. Your letter must also say whether or not you got services from non- <plan name> doctors since <original effective date of disenrollment>. If you did not get any services from non- <plan name> doctors since <original effective date of disenrollment>, we will fix our records after we receive your letter. *You can mail your letter to us at <address>. Or you can fax it to us at <fax number>.*

[*If PCP not applicable, omit the following sentence. The term "physicians" or "doctors" or "providers" instead of "primary care physician," if that is more appropriate:* In the meantime, you should keep seeing your <plan name> primary care physician for your health care.

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

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

Exhibit 18: Model Notice to Close Out Request for Reinstatement

Referenced in section(s): 60.3.2

Dear <Name of Beneficiary>:

We cannot process your request to be reinstated in <plan name> because we have not received *[*your letter asking for reinstatement*, the information we requested]*. As discussed in our letter of <date of letter> you must send us *[*a letter*, this information]* by <date placed on notice in Exhibit *16 or* 17>.

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

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

Thank you.

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

Referenced in section: 50.3.1

Dear <Name of Member>:

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

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

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

[*MA organizations who will downgrade the membership for all members use the following sentences:* If we do not receive payment by <date grace period expires>, we will make some changes to your membership in <plan name> that will reduce the amount of health care coverage you have in <plan name>. This means that (describe lower level of benefits, e.g., routine dental care will not be covered) beginning <date>.]

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

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

If you wish to disenroll from <plan name> and change to the Original Medicare Plan now, you should do one of these two things:

1. Send us a written request at <MA Plan address>.

2. Call 1-800-MEDICARE(1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

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

- **From January 1 until March 31**, anyone with Medicare (including members of <plan name>) has one opportunity to make a change in the way they get Medicare.

- **From November 15 through December 31**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

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

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

Thank you.

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

Referenced in section(s): 50.3.1

Dear <Name of Member>:

On <date> we sent you a letter that said your plan premium was overdue. The letter said that if we did not get payment from you, we would disenroll you from <plan name>. Since we did not receive that payment, we asked Medicare to disenroll you from <plan name> beginning <date>.

Due to your disenrollment from <plan name>, you will be covered by the Original Medicare Plan, beginning <effective date>. You have the right to ask us to reconsider this decision through the grievance procedure written in your [insert "Member Handbook" or "Evidence of Coverage", as appropriate].

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

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

- **From January 1 until March 31**, anyone with Medicare (including members of <Plan Name>) has one opportunity to make a change in the way they get Medicare.

- **From November 15 through December 31**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

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

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

[***MA-PD plans insert:*** Please remember, if you do not enroll in another Medicare Advantage Plan with prescription drug coverage (or a Medicare Prescription Drug Plan) or if you do not obtain other creditable coverage as good as Medicare, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

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

Thank you.

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

Referenced in section(s): 50.3.1

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <plan name> due to non-payment of plan premium. Your disenrollment begins <effective date>.

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

- **From January 1 until March 31**, anyone with Medicare (including members of <Plan Name>) has one opportunity to make a change in the way they get Medicare.

- **From November 15 through December 31,** anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

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

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

[*MA-PD plans insert:* Please remember, if you disenroll and do not enroll in another Medicare Advantage Plan with prescription drug coverage (or Medicare Prescription Drug Plan) or if you do not obtain other creditable coverage as good as Medicare, 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, or need help, please call *<plan name>* at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.

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

Referenced in section(s): 50.3.1

Dear <Name of Member>:

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

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

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

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

1. Send us your written request to <plan name> or fax it to us at <fax number>.

2. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7days a week.

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

- **From January 1 until March 31**, anyone with Medicare (including members of <Plan Name>) has one opportunity to make a change in the way they get Medicare.

- **From November 15 through December 31,** anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.

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

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

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

Thank you.

Exhibit 23: Model Notices for Closing Enrollment

Referenced in section(s): 30.8.1

Model A: Closing Enrollment for Partial Month(s)

[Insert name of MA organization] PUBLIC NOTICE

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

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

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

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals during the Annual Election Period from November 15 to December 31.

Current members of <plan name> are not affected by this change. For information regarding this notice, call <MA organization> at <phone number> between <hours and days of operation>. TTY users should call [insert TTY/ number].

Model B: Closing Enrollment for Whole Month(s)

<MA organization> PUBLIC NOTICE
As of <date> <MA organization> will no longer offer open enrollment under its Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS) for <plan name> in <service area>.

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

Also, <MA organization> will continue to accept enrollments into <plan name> from all eligible individuals during the Annual Election Period from November 15 to December 31.

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

Model C: Closing Enrollment for Capacity Reasons

<MA organization> PUBLIC NOTICE

As of <date>, <MA organization> will no longer accept enrollment under its Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS) for <plan name> in <insert service area>.

The <plan name> has been approved for a capacity limit by CMS. A capacity limit allows a Medicare Advantage Organization to limit enrollment in a plan once a specific number of people join the plan. This is based primarily on the accessibility and availability of providers to provide services to members of the plan.

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

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

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

Referenced in section(s): 50.1 and 50.2

Dear <Name of Beneficiary>:

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

_____ You permanently moved.

_____ You receive assistance from the Medicaid program.

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

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

Please save this letter as proof of your Medigap rights.

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

Thank you.

Exhibit 25: Acknowledgement of Request to Cancel Enrollment

Referenced in section(s): 60.2.1

Dear <name of applicant>:

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

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

If you were enrolled in another Medicare Advantage Plan before enrolling with <plan name>, you may appear on their records as being disenrolled. If your intent is NOT to disenroll with that plan, you will need to notify them that you enrolled in <plan name> and 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 creditable prescription drug 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 <plan name> at <number>, Monday through Friday between the hours of <hours>. TTY users should call <TTY number>.

Thank you.

Exhibit 26: Acknowledgement of Request to Cancel Disenrollment

Referenced in section(s): 60.2.2

Dear <name of member>:

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

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

If you have any questions, please contact <plan name> at <phone number>, Monday through Friday between the hours of <hours>. TTY users should call <TTY number>.

Thank you.

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

Referenced in section: *40.1.5*

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

Dear <insert member name>

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

> **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.

Starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <plan name> doctor(s). You will need to pay our copayments when you get health care. [*Optional:* This letter is proof of insurance that you should show during your doctor appointments**.]**

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

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

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

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

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

[***MA PPO plans use the following paragraph*:** Beginning <effective date>, you will receive your health care as provided in your <*insert either "Member handbook" or "Evidence of Coverage''*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

[***MA PFFS plans use the following paragraph:*** Beginning <effective date>, you will begin to receive your healthcare from <new plan name>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. *<MA-PD plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.* You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.*]*

Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <new plan name>.

If you have other types of prescription drug coverage, or if your employer or union pays for your enrollment in <name of MA-only plan>, 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/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 would hurt your other benefits.

You aren't required to be in our Medicare prescription drug plan and have the option to stay in <name of MA-only plan>. You can also decide to join a different Medicare prescription drug plan (call 1-800-MEDICARE for help in learning how). If you decide not to be enrolled 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 penalty to join later. If you don't want Medicare prescription drug coverage, call *<plan name>* at <phone number>. TTY users should call <TTY number> within 10 days of the date on this letter. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 27a: MA-PFFS Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP

Referenced in section: *40.1.5*

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

Dear <insert member name>

Our records show that you have Medicare and Medicaid. *<Insert for those with retroactive effective dates:* To make sure that you don't lose a day of your drug coverage,> *<Insert for those with prospective effective dates:* To make sure you have prescription drug coverage,> Medicare is enrolling you in our <PDP name> that offers Medicare prescription drug coverage, beginning <effective date>, unless you tell us you don't want to join our plan.

> **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.

Starting <effective date>, all of your health care will continue to be covered under your <current MA-only plan name> and your pharmacy coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan> will not change. **[Optional:** You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]

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

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

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

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

Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>.

If you have other types of prescription drug coverage, or if your employer or union pays for your enrollment in <current MA-only plan name>, 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 would hurt your other benefits.

You aren't required to be in our Medicare prescription drug plan and have the option to stay in <current MA-only plan name>. You can also decide to join a different Medicare prescription drug plan (call 1-800-MEDICARE for help in learning how). If you decide not to be enrolled 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 penalty to join later. If you don't want Medicare prescription drug coverage, call *<plan name>* at <phone number>. TTY users should call <TTY number> within 10 days of the date on this letter. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment into MA-PD plan

Referenced in section: *40.1.5*

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

Dear <insert member name>

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

[***MA PPO and PFFS plans do not use the following paragraph:*** Starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <MA-PD plan name> doctor(s). You will need to pay our copayments when you get health care. [*Optional:* This letter is proof of insurance that you should show during your doctor's appointments until you get your member card from us**.]**

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

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

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

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

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

[***MA PPO plans use the following paragraph:*** Beginning <effective date>, you will receive your health care as provided in your <*insert either "Member handbook" or 'Evidence of Coverage'*>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.

[***MA PFFS plans use the following paragraph:*** Beginning <effective date>, you will begin to receive your healthcare from <MA-PD plan name>, which allows you to go to any Medicare-approved doctor or hospital that is willing to give you care and accept our plan's terms of payment. *<MA-PD plan name>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.* You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.]

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in <MA-only plan name>, 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 Medicare drug coverage would hurt your other benefits.

You aren't required to be in our *<MA-PD plan name> that offers Medicare prescription drug coverage* and have the option to stay in <MA-only plan name>. You can also decide to join a different Medicare prescription drug plan (call 1-800-MEDICARE for help in learning how). If you decide not to be enrolled 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 penalty to join later. If you don't want Medicare prescription drug coverage, call *<plan name>* at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 28a: MA Model Notice to Inform Member of Facilitated Enrollment into PDP

Referenced in section: *40.1.5*

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

Dear <insert member name>

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

Starting <effective date>, all of your health care, will continue to be covered under your <current MA-only plan name>, and your pharmacy coverage will be provided through our <PDP name>. Your medical benefits and member copayments under <current MA-only plan name> will not change. **[***Optional:* You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]

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

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

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

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

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in <current MA-only plan name>, 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 would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan. You can also decide to join a different Medicare prescription drug plan (call 1-800-MEDICARE for help in learning how). If

you decide not to be enrolled 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 a penalty to join later. If you don't want Medicare prescription drug coverage, call *<plan name>* at <phone number>. TTY users should call <TTY number> within 10 days of the date on this letter. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

Exhibit 29: Acknowledgement of Request to Opt Out of Auto/Facilitated Enrollment

Referenced in section(s): *40.1.5*

Dear <name of member>:

As requested, we have processed your request to decline (opt out of) Medicare prescription drug coverage. You will continue to be a member of <plan name> that does not offer Medicare prescription drug coverage.

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

Remember, even if you don't use a lot of prescription drugs now, you still should consider joining a Medicare prescription drug plan. As we age, most people need prescription drugs to stay healthy. If you don't join a prescription drug plan when you are first eligible to join, and you don't have prescription drug coverage that covers at least as much as Medicare's (also referred to as "creditable prescription drug coverage"), you may have to pay a penalty to join later. You will have to pay the penalty in addition to your premium as long as you have a Medicare drug plan.

If you change your mind now and would like to join, you can call <plan name> at <phone number>, Monday through Friday between the hours of <hours>. TTY users should call <TTY number>.

Thank you.

Exhibit 30: Model Notice for Enrollment Status Update

(For use with Transaction Reply Codes (TRC) from User Interface (UI) changes)

Referenced in section: 60.7

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

Dear <Name of Member>:

Your enrollment in <Name of Plan> has been updated.

[*Insert one or more of the following, including sufficient detail to describe the specific enrollment change:*

- You have been enrolled in <name of plan>. Your coverage will start on <*insert start date*> and will end on <*insert end date*>. [*Insert information about premiums, if applicable, and how to access coverage, etc*.].

- Your enrollment in <*name of plan/old PBP*> has been changed to <name of plan/new PBP>. Your coverage in <*name of plan/new PBP*> will start on <*date*>. [*Insert information on premium differences (if any), cost sharing information, and other details the individual will need to ensure past and future coverage is clear*]

- Your enrollment in <*Name of Plan*> has been changed to start on an earlier date. Your coverage will start <*date*>. [*Include information about premiums and coverage*]

- Your enrollment in <*Name of Plan*> has been changed to start on a later date. Your coverage with <*Name of Plan*> will start on < *date*>. [*Insert information about refunding premium, where applicable, and impact to paid claims*]

- Your enrollment in <*Name of Plan*> [*ended, will end*] on < *date*>. This means you [*don't, won't*] have coverage from <*Name of Plan*> after <*date*>. [*Insert appropriate descriptive information, such as premium owed if the date has moved forward, or premium refunds if the date has moved back, and impact on paid claims or how to submit claims, as applicable*]

- Your enrollment in <*Name of Plan*> has been cancelled. This means that you don't have coverage from <*Name of Plan*>. [*Insert information about refund of premium, if applicable, and impact to any paid claims*]

[*Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary*]

[Insert if enrolling in a PFFS plan: <Name of Plan>, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our

payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at <insert link to PFFS terms and conditions>.]

Call <*toll-free number*> <*days and hours of operation*> to get more information. TTY users should call <*toll-free TTY number*>.

Thank you.

Exhibit 31: Model Employer/Union Sponsored MA Plan Group Enrollment Mechanism Notice

Dear (name)

<Name of Employer/Union> is enrolling you in <plan name > as your retiree health benefit plan beginning <effective date>, unless you tell us you don't want to join our plan.

Included in this mailing is important information about this plan and the coverage it offers, including a summary of benefits document. Please review this information carefully. You have until <insert date no less than 21 days from date of notice> to consider this enrollment option. If you want to be enrolled in this Medicare health plan, you do not have to do anything, and your enrollment will automatically begin on <effective date>.

You are not required to be enrolled in this plan. <insert information about other group sponsored plan options, if there are any>. You can also decide to join a different Medicare plan (call 1-800-MEDICARE for help in learning how). However, if you decide not to be enrolled <insert consequences for opting out of group plan, like that you cannot return, or that other benefits are impacted>. To request not to be enrolled by this process <insert clear instruction for opting out including telephone numbers and times of operation where those numbers will be answered>.

*By taking no additional action, you are agreeing to enroll in <plan name>. You will need to keep Medicare Parts A and B as <Plan Name> is a Medicare Advantage plan. You can be in only one Medicare Advantage plan at a time. It is your responsibility to inform <Plan Name> of any prescription drug coverage that you have or may get in the future. [**MA-only plans insert the following, unless the employer/union provides other creditable coverage:** You understand that if you do not have 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.] Enrollment in this plan is generally for the entire year. You may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Plan Name> or by calling 1-800-Medicare. TTY users should call 1-877-486-2048, 24 hours a day/7days a week.*

<Plan Name> serves a specific service area. If you move out of the area that <Plan Name> serves, you need to notify the plan so you can disenroll and find a new plan in your new area. Once you are a member of <Plan Name>, you have the right to appeal plan decisions about payment or services if you disagree. You agree that you will read the [insert either Member Handbook or Evidence of Coverage document] from <plan name> when you receive it to know which rules you must follow in order to receive coverage with this Medicare Advantage plan. You understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

*[**MA PFFS do not include the following paragraph:** You understand that beginning on the date <plan name> coverage begins, you must get all of your health care from <plan name>, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services*

authorized by <plan name> and other services contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, ***NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.]***

Release of Information: *By joining this Medicare health plan, you acknowledge that the Medicare health plan will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <plan name> will release your information [****MA-PD plans insert:*** *including your prescription drug event data] to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.*

Thank you.

Exhibit 32: Model Notice for Loss of Special Needs Status (Exclusive SNP)

Referenced in section: 50.2.5

Dear <Name of Member>:

Our records indicate that you no longer <describe special needs status that individual has lost>. To be a member of <plan name>, you must <describe required special needs status>.

<Plan name> will continue to cover your Medicare benefits until <insert end date for period of deemed continued eligibility>. You have <insert length of period of deemed continued eligibility> to re-qualify for our plan.

If, at the end of <insert length of period of deemed continued eligibility>, you have not <describe special needs criteria that must be met> and you have not enrolled in a different plan, we will disenroll you and you will be covered by the Original Medicare Plan beginning < insert end date for period of deemed continued eligibility >.

When coverage from <plan name> ends, your Medicare prescription drug coverage ends too. In order to have new health care coverage and prescription drug coverage after <date> or to buy a Medigap policy while you still have a guaranteed right to buy one, you need to take action. For example, if you are returning to Original Medicare coverage, to receive Medicare prescription drug coverage you must join a Medicare prescription drug plan. Please remember, if you disenroll from <plan name> and do not enroll in another Medicare Advantage Plan with prescription drug coverage (or Medicare Prescription Drug Plan) or if you do not obtain other creditable coverage as good as Medicare, you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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

- ***From January 1 until March 31**, anyone with Medicare (including members of <Plan Name>) has one opportunity to make a change in the way they get Medicare.*

- ***From November 15 through December 31**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.*

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

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

However, because you are no longer eligible for our plan, Medicare will give you a special one-time opportunity to change to a different Medicare Advantage plan or Medicare prescription drug plan. This opportunity begins now and ends when you enroll in a different plan or on <insert date three months after the expiration of the period of deemed continued eligibility>, whichever is earlier. If you don't take any action, <plan name> will continue to cover your Medicare benefits until <insert end date for period of deemed continued eligibility>.

If this information is wrong and you continue to be eligible for <plan name> or if you believe you have already re-qualified for our plan and you want to stay a member of our plan, please contact us immediately at <phone number>. TTY users should call <TTY number>. We are open <insert days and hours of operation>.

Thank you.

Exhibit 33: Model Notice for Loss of SNP Status - Notification of Involuntary Disenrollment (Exclusive SNP)

Referenced in section(s): 50.2.5

Dear <Name of Member>:

On <date> we sent you a letter that said you no longer <describe special needs status that individual has lost>. The letter said that if you did not <describe special needs criteria that must be met>, we would disenroll you and you would be covered by the Original Medicare Plan beginning < insert end date for period of deemed continued eligibility >. According to our records, you remain ineligible for <plan name>. Therefore, we asked Medicare to disenroll you from <plan name> beginning <date>.

Due to your disenrollment from <plan name>, you will be covered by the Original Medicare Plan, beginning <effective date>.

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

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

- ***From January 1 until March 31**, anyone with Medicare (including members of <Plan Name>) has one opportunity to make a change in the way they get Medicare.*

- ***From November 15 through December 31**, anyone with Medicare can switch from one way of getting Medicare to another for the following year, including when you can enroll in Medicare prescription drug coverage.*

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

If you qualify for extra help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this extra help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for extra help.

As described in our earlier letter, you have a special one-time opportunity to enroll in a different Medicare Advantage plan or Medicare prescription drug plan. This opportunity will end when you enroll in a different plan or on <insert date three months after the expiration of the period of deemed continued eligibility>, whichever is earlier.

Please remember, if you do not enroll in another Medicare Advantage Plan with prescription drug coverage (or a Medicare Prescription Drug Plan) or if you do not obtain other creditable coverage as good as Medicare, 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 call us at <phone number> between <hours and days of operation>. TTY users should call <TTY number>.

Thank you.