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CENTER FOR BENEFICIARY CHOICES

DATE April 11, 2008

To: All Prescription Drug Plan Sponsors, Medicare Advantage Organizations, Section 1876 Cost-Based Contractors and PACE Organizations

Subject: Updated Guidance on Creditable Coverage Period Determinations and the Late Enrollment Penalty

From: Anthony Culotta, Director, Medicare Enrollment and Appeals Group

The purpose of this memorandum is to update our current guidance on creditable coverage determinations and related late enrollment penalty issues. (See Chapter 4: Creditable Coverage Period Determinations and the Late Enrollment Penalty and section 80.7.1 of Chapter 18: Late Enrollment Penalty Reconsiderations in the Medicare Prescription Drug Benefit Manual, as issued on June 12, 2007). This memo clarifies our policy in a number of areas based on our experience implementing this guidance, and in response to questions received through our central mailbox. These policy clarifications are effective immediately and will be incorporated into Chapters 4 and 18 in the next update of these chapters. We have also updated several exhibits, including the model attestation form and reconsideration request form, which are attached to this memo.

Determining the Number of Uncovered Months

As described in the October 9, 2007 HPMS memorandum, "Announcement of Fall Software Changes," CMS has improved the way it processes the number of uncovered months for Part D plans, and the way in which plans report this information on an enrollment or change transaction. We are providing further information about the impact of those changes, including examples, in response to plans' requests. The most significant change for plans is that, for members with prior Part D plan or Retiree Drug Subsidy (RDS) enrollment, the plan only needs to determine whether the member has any period without creditable coverage ("uncovered months") since the date s/he disenrolled from the prior Part D or RDS plan. That is, where there is a prior enrollment in a Part D or RDS plan, the current plan does not need to look all the way back to the end of the member's initial enrollment period (IEP), which is the procedure now outlined in Section 10.2 of Chapter 4.

Instead, once the plan determines there was prior Part D/RDS plan coverage, whether through a Beneficiary Eligibility Query (BEQ) or through the Common User Interface (Common UI), the plan will look for any lapse of Part D or RDS enrollment of 63 or more consecutive days between the effective date of the member's disenrollment from the prior plan and the effective

date of the member's enrollment in the new plan, as explained in section 10 of Chapter 4. If there are potential uncovered months because the plan's review of this data shows a period of 63 days or longer between the two enrollments, the plan will then follow the procedures to determine if the full months within that period are genuinely "uncovered" (i.e., the individual did not have other creditable coverage.) Once it is determined that there is a number of uncovered months, the plan will submit those months as "incremental months" on a Part D enrollment transaction (60/61/62/71) or a plan change transaction (72) if enrollment has already been submitted. CMS will then add these months to any other uncovered months submitted by the prior plan(s), if applicable. CMS will adjust the amount of the LEP, as appropriate, to reflect the increase in uncovered months, and notify the plan of the change in LEP amounts. Below are two examples to illustrate this process:

Example 1: Plan Submits Incremental Uncovered Months

Mr. Jones submits an enrollment request to Plan XYZ during the 2008 Annual Enrollment Period, with enrollment effective on January 1, 2008. Plan XYZ learns via the BEQ that Mr. Jones was enrolled in Plan ABC effective January 1, 2007, but disenrolled effective July 31, 2007. Plan XYZ also sees (via the BEQ) that Mr. Jones' IEP ended May 15, 2006, and that Plan ABC had submitted 7 uncovered months on his behalf.

Since Mr. Jones' enrollment in Plan XYZ will be effective on January 1, 2008, and his last Part D plan enrollment ended on July 31, 2007, he will potentially have 5 uncovered months between the effective date of his disenrollment from Plan ABC at the end of July, through the end of December. In accordance with CMS guidance, Plan XYZ sends Mr. Jones an attestation form, and learns that he did not have other creditable coverage during this time, and therefore this period represents a total of 5 uncovered months. Plan XYZ then submits a Plan change (code 72) transaction on behalf of Mr. Jones that sets the creditable coverage flag to "N" and inserts "005" as the number of uncovered months, effective with the beneficiary's enrollment with the Plan. CMS then adds these uncovered "incremental" months to the 7 months already submitted for Mr. Jones by Plan ABC, for a total of 12 uncovered months, and CMS adjusts the penalty accordingly. Plan XYZ notifies Mr. Jones of the adjustment to his LEP, as outlined in section 30.1 of Chapter 4.

Example 2: Plan Submits No Incremental Uncovered Months

Mrs. Smith submits an enrollment request to Plan XYZ during the 2008 Annual Enrollment Period, with enrollment effective on January 1, 2008. Plan XYZ learns via the BEQ that Mrs. Smith is currently enrolled in Plan ABC, effective January 1, 2007 and has "0" uncovered months reported by Plan ABC. Mrs. Smith's enrollment in Plan XYZ will disenroll her from Plan ABC effective December 31, 2007. Therefore, she will have no break between these two Part D plans and there is no break in creditable coverage. Plan XYZ would then set the creditable coverage flag to "Y" and submit "000" uncovered months for Mrs. Smith on a Part D enrollment transaction (60/61/62). Since there are no prior uncovered months submitted by Plan ABC, the total number of uncovered months will be zero, and there will be no LEP.

Note: If the member is enrolling in Part D for the first time, then the plan will still have to look back to the end of the member's IEP, and report any uncovered months, as explained in section 10 of Chapter 4. Plans may use either the BEQ or Common UI to obtain Part D and RDS plan history for a beneficiary; both will display correct information about prior Part D plan enrollment and/or coverage under a plan receiving the Retiree Drug Subsidy (RDS), as well as provide information regarding the number of uncovered months submitted by any Part D plan in which the individual was previously enrolled.

Revised Attestation Form and New Checklist

Since our independent review entity, currently Maximus, began processing beneficiary's requests for a reconsideration of the LEP last fall, we have learned that the majority of the requests are from beneficiaries who had creditable coverage during the period in question, but failed to submit or complete the attestation form. In these cases, Maximus ultimately issues a favorable decision for those beneficiaries who can show that they had prior creditable coverage, but not until considerable time and resources have been expended on the part of the beneficiary, the plan, Maximus, and CMS. We are also concerned, based on anecdotal information, that beneficiaries do not understand the form or appreciate the importance of completing and submitting the form timely.

Therefore, we have taken a number of steps to address this issue, first by simplifying the current attestation form. The simplified attestation form includes a checklist designed to focus beneficiaries' attention on the form, and emphasizes the urgency of completing the attestation process. (See Exhibit 1A). Second, we have added a new model notice for plans to remind enrollees of the need to submit a timely attestation if they have prior creditable prescription drug coverage. This model serves as a "final notice" that an LEP will be imposed if the enrollee does not return the attestation form or call their plan with this information by the stated deadline. (See Exhibit 1B).

These documents are provided as models and may therefore be modified, subject to CMS review and approval. However, we urge plans to refrain from adding extraneous information to either the form or the checklist, or from putting their own letterhead on the checklist in addition to the CMS letterhead. We believe that emphasizing to beneficiaries that the information about prior coverage is being collected on behalf of Medicare will dispel any notions (as shown by anecdotal reports) that the plan is collecting this information for other purposes, or that the request is not legitimate.

Plans must begin using these new models with enrollments received on or after June 1, 2008, but may begin using them sooner, and are, in fact, encouraged to do so. Neither the previous model nor previously-approved notices should be used after that date. As noted above, using the new form immediately should be in the best interests of both plans and beneficiaries, since timely completion of the form will reduce the burden associated with the reconsideration process on all parties involved.

Mailing of Attestation Forms to Members

Please note that plans may not include the attestation form with an enrollment form, nor may they include a question(s) regarding the individual's creditable coverage on the enrollment form, as doing so may lead the enrollee to believe that his/her enrollment in the plan is contingent upon having prior creditable coverage. CMS has also removed questions about creditable coverage from its model enrollment form for 2008. However, if the beneficiary, on his/her own initiative, includes creditable coverage information and/or documentation with the enrollment form, the plan shall take that information into account when determining whether there has been a gap in coverage. Thus, the plan may not need to send an attestation form if the documentation shows that there is no gap in coverage.

Plans may not send the LEP Reconsideration Notice and Reconsideration Request Forms to members with the attestation form. Experience has shown that doing so confuses the beneficiary and prompts reconsideration requests in situations where no LEP will be assessed. Plans are advised to ensure that their call center staff has proper scripting, so that they can answer questions about the attestation form.

Other Information About Creditable Coverage

In addition to information from the BEQ or Common UI, Part D sponsors should rely on other available information to determine that there is no lapse in creditable coverage of 63 or more consecutive days. For example, a sponsor may be able to document that a new member of its Part D plan also had creditable coverage through another product it offers, i.e., employer coverage, individual coverage, or coverage offered by another plan benefit package (PBP). If this information shows that there has been no lapse in coverage, the sponsor should not send an attestation form to the member, but instead include appropriate documentation in the member's file and report zero uncovered months to CMS.

Attestations from Third Parties

CMS currently allows employers and unions that enroll groups of beneficiaries into Medicare prescription drug coverage to attest to their members' creditable coverage history with the employer or union for purposes of reporting covered months. (See Chapter 4, section 10.2.4.) We will now allow any employer or union group to attest to their members' creditable coverage history, even if they do not also group enroll their members. We continue to refrain from specifying the form and manner of that attestation and instead defer to arrangements made between the plan and the employer or union group. For example, documentation can include individual attestations signed by the employer or union, or one attestation, supplemented by a list of affected members. Plans shall accept and retain such attestations and provide the documentation to CMS upon request.

We are also further expanding our policy to allow State Pharmaceutical Assistance Programs (SPAPs) to attest to creditable coverage on their members' behalf. As with employer or union groups, plans shall accept attestation information from the SPAP that includes members' names and dates of creditable SPAP coverage.

Note: In the event that an employer, union, or SPAP attests to creditable coverage on behalf of its members, but a member has also completed an attestation form, the plan shall use the information most favorable to the beneficiary. Thus, the information provided by the employer, union, or SPAP will supersede the beneficiary's signed attestation only if it would eliminate or reduce the LEP.

Telephonic Attestation

As discussed above, we are concerned that beneficiaries may not understand the attestation form or appreciate the importance of completing the form and returning it to their plan in a timely fashion. We understand that some plans have made follow-up telephone calls to their members who fail to complete the form in order to encourage them to complete the form. These plans have explained that, to the extent they are able to reach their members via phone, they could complete the attestation process more quickly and effectively if they were able to accept the attestation over the phone, rather than relying on the beneficiary to complete the form and return it. Thus, we are expanding our policy to allow beneficiaries or their authorized representatives to complete the entire attestation over the telephone. The plan sponsor is not required to record the conversation, but must document the call and ensure that it captures all of the requisite elements of the attestation (shown in the attached model attestation form) and amend the beneficiary's record. We would note that this new telephonic option is only available where the member has failed to return or complete the form. Plans are still required to mail an attestation form to their members. We have modified the model attestation form (Exhibits 1A/1B) to include language for plans that offer telephonic attestation.

Currently, plans are permitted to obtain missing information via telephone, but must obtain the beneficiary's "wet" signature on the actual form. Consistent with our expanded policy allowing telephonic attestation, beneficiaries can now verbally attest to the information already provided via telephone in lieu of providing a "wet" signature on the form. As noted above, plans are not required to record the conversation with the beneficiary, but must amend the beneficiary's record.

Determinations Based on Incomplete or Missing Attestation Forms

Currently, plans are strongly encouraged to follow-up with their members, either via phone or in writing, to obtain any missing information or to obtain the actual form, if none has been returned. If a beneficiary returns an incomplete attestation, the plan must report its determination to CMS within 21 calendar days of receipt of the incomplete form. Effective with this guidance, CMS is affording plans an additional 7 calendar days (for a total of 28 days) to attempt to obtain missing information and report its determination to CMS.

Currently, beneficiaries have 30 days from the date on the form to complete and return the form to the plan. If the beneficiary fails to return the attestation form by the stated deadline, the Part D plan sponsor must report its determination to CMS within 7 calendar days of the stated deadline. Consistent with the additional time afforded for incomplete attestation forms described above, plans have an additional 7 calendar days (for a total of 14 calendar days) beyond the deadline on the form to report their determinations to CMS.

Again, plans are strongly encouraged to follow-up with the beneficiary via phone or other methods to obtain a completed form, or obtain the necessary information and a verbal confirmation from the beneficiary, as described above. It is certainly in plans' best interests to attempt to contact the beneficiary and obtain the necessary information or the attestation itself, since, in doing so, the plan may avoid having to expend additional resources in the future if the beneficiary chooses to request a reconsideration. Plans should document any such follow-up attempts in the beneficiary's file.

Note: While plans are not required to retain copies of the attestation form mailed to the beneficiary, the plan must be able to document the information included in the attestation form (i.e., the dates of non-coverage and the IEP end date) and the date that the form was mailed to the member in the event that there is a reconsideration of any LEP imposed. We encourage plans to retain copies of the attestation form, where possible, to help expedite the reconsideration process because this form contains member-specific information that would be valuable in the case of a reconsideration. Plans are already required to retain copies of the returned attestation form, along with any other information collected concerning a creditable coverage period determination, as explained in Chapter 4, section 10.4.

Determinations Pending Retroactive Enrollment

If the plan or member has requested a valid retroactive enrollment that would impact (positively or negatively) the number of uncovered months for that member, the plan shall wait until the retroactive enrollment request has been accepted and processed prior to submitting any uncovered months on behalf of that member, even if doing so delays the plan's reporting of that information past the timeframes described in this memorandum. The plan will not be considered out of compliance with these procedures under these circumstances.

Corrections to Reports of Creditable Coverage Period Determinations

In the event a plan discovers it has erroneously calculated the number of uncovered months, or erred in transmitting that information to CMS (e.g., a typographical error in the transaction), the plan shall take steps to correct the error by submitting a change transaction (code 72) with the correct information. The transaction must have the same effective date as the erroneous transaction. In limited circumstances, there may be a change to the number of uncovered months because of a corresponding change in a member's enrollment effective date. The plan shall also submit a change transaction with the appropriate effective date and the correct number of uncovered months in this case.

The plan must then advise the member of the adjustment within ten (10) calendar days of receiving confirmation from CMS that the transaction was accepted. The plan may use the model notice entitled, *Exhibit 6: Model Notice Informing Beneficiary of LEP Adjustment Due to Plan Error,* for this purpose or create its own form using the requisite elements shown in the model, subject to CMS' marketing review procedures.

If such a change results in the imposition of or increase in the LEP, the plan must include the LEP Reconsideration Notice and Reconsideration Request Form with notice of the LEP. If, on

the other hand, such a change results in the elimination or reduction of the LEP, the beneficiary is afforded no new reconsideration rights, and the plan need not include the forms.

If the member has already requested a review of the LEP before the plan submits a transaction with the corrected number of uncovered months, and CMS' independent review entity (Maximus) has notified the plan of a pending reconsideration request (i.e., the independent review entity has requested the case file from the plan), the plan must contact Maximus to alert them to the change and provide documentation of the change. Plans should use the fax number noted on the LEP Reconsideration Case File Request Form to communicate this information to Maximus (484-688-5601 for PDP plans and 585-425-5301 for MA-PD plans). If the correction results in removal of the LEP (zero ["0"] uncovered months), Maximus will then dismiss the case because there are no longer uncovered months in dispute. If, however, the correction adjusts but does not eliminate the LEP, Maximus will then proceed with its review of the LEP based on the new information.

Effective with this guidance, plans must submit corrections when they receive a late attestation form that indicates that the member had creditable coverage for the period in question, if the plan has already reported uncovered months to CMS. (Currently, plans have the discretion to not report this information to CMS.) Again, plans should use a change transaction (code 72) to do so. We have eliminated the model notice entitled, *Exhibit 9: Model Notice – Creditable Coverage Information Received After Deadline Date* since this is no longer needed.

Creditable Coverage Period Determinations for Disenrolled Members

When a beneficiary submits a valid cancellation request to the plan prior to his/her enrollment effective date (see the CMS Eligibility, Enrollment, and Disenrollment Guidance appropriate to your plan type for information on valid cancellation requests), the plan should not proceed with a creditable coverage period determination in accordance with section 10 of Chapter 4. However, if the member's coverage is already effective, and the beneficiary later disenrolls from the plan before the plan has had an opportunity to assess the LEP, the plan shall continue with a creditable coverage period determination in accordance with CMS guidance, and report the number of uncovered months to CMS. The reason it is important that plans proceed with their determination is that subsequent plans will not look back beyond the end of the beneficiary's enrollment in the previous plan when determining the number of uncovered months.

LEP Reconsideration Process

Plans are reminded to include the LEP Reconsideration Notice and Reconsideration Request Form when notifying their members of the imposition of or increase in the LEP where the increase is due to reporting additional uncovered months. Please see the "New and Revised Appendices and Exhibits" section below for revisions to the Reconsideration Notice and Reconsideration Request form. Plans must begin including the notice and form on or after June 1, 2008, but are encouraged to do so sooner if practical.

In addition, plans must now retain copies of the LEP notice sent to their members. We have learned from Maximus that the information included in the LEP notice about the end of the

member's IEP and the dates of the potential gap in creditable coverage is important in the event that the beneficiary requests a reconsideration, and some plans that do not retain a copy of the notice have not been able to provide that information to Maximus when requested. If the plan retains a copy of the LEP notice in the member's file, then that information will be readily and easily available should the beneficiary request review of the LEP. We will revise existing guidance at section 10.4 of Chapter 4 and section 80.7.1 of Chapter 18 accordingly.

Based on our experience reviewing LEP reconsideration cases to date, we are making several revisions to our LEP reconsideration policy. We are revising existing guidance concerning the reasons a beneficiary may request an LEP reconsideration (section 80.7.1.4 of Chapter 18). The LEP Reconsideration Request Form will no longer include a reference to review of an LEP for "special circumstances." Instead, in order to provide clearer guidance on when an LEP may be reviewed, the LEP Reconsideration Request Form has been revised to include the following specific reasons for requesting a reconsideration:

1. The individual had prior creditable prescription drug coverage (that the enrollee believes may have not been considered).
2. The individual had prior prescription drug coverage but didn't get a notice that clearly explained if the drug coverage was as good as Medicare's (creditable).
3. The individual believes the LEP is wrong because he or she was not eligible to enroll in a Medicare drug plan during the period stated by the Medicare drug plan.
4. The individual believes the LEP is wrong because he or she was unable to enroll in a Medicare drug plan due to a serious medical emergency during the period the individual was eligible to enroll in a drug plan.
5. The individual has/had extra help from Medicare to pay for prescription drug coverage.
6. The individual lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005), and he or she joined a Part D plan before December 31, 2006.

Also, we are revising existing guidance concerning the LEP reconsideration decision-making timeframe (section 80.7.1.5 of Chapter 18). Under this revised guidance, the IRE generally will notify the enrollee of the final LEP reconsideration decision within 90 calendar days of receiving an enrollee's reconsideration request. As noted in current guidance, the IRE may take an additional 14 days if the enrollee requests an extension or if the IRE finds good cause to extend the timeframe – e.g., if the IRE finds a need for additional information and considers the delay to be in the interest of the enrollee (see section 80.7.1.5 for further details).

In all LEP reconsideration cases, the IRE will continue to strive to notify enrollees of the decision as quickly as possible. However, because of the large volume of requests being filed by enrollees and the additional time required to obtain information related to prior prescription drug coverage (for example, evidence of coverage from an employer sponsored plan), it may take longer than the 30-day timeframe set out in current guidance for the case to be resolved. Unlike Part D prescription drug benefit appeals, there is no prescribed statutory or regulatory timeframe for issuing decisions related to an LEP. Thus, until further notice, we are extending the general LEP reconsideration processing timeframe to 90 days, in order to establish reasonable expectations for when these cases are likely to be processed.

Reconsideration decisions may uphold, increase, decrease or eliminate the current number of uncovered months. When CMS' independent review entity notifies the plan of a decision that results in any adjustment to or removal of the LEP, the plan must take the following steps:

- If the LEP is to be removed completely, the plan must submit a Plan Change transaction (code 72) with the creditable coverage flag "Y" and the number of uncovered months = "0." The effective date on the transaction is equal to the effective date of enrollment in the plan that submitted the number of uncovered months that needs to be removed.
- If the LEP is adjusted to a number other than "0" due to a change in the number of uncovered months, the plan must submit a Plan Change transaction (code 72) with the creditable coverage flag "N" and the new adjusted number of uncovered months. The effective date on the transaction is equal to the effective date of enrollment in the plan that submitted the number of uncovered months that needs to be changed.

Any period of time determined to be a period of uncovered months for the purposes of the Part D LEP always occurs outside a Part D plan enrollment period. Thus, the effective date of the "number of uncovered months" data is always equal to a Part D plan enrollment effective date, with two exceptions. Those exceptions are when an individual becomes LIS eligible (see section *"Removal of the LEP Due to LIS Eligibility*"); and when an individual has a second Part D IEP (see section "*Reporting Adjustments to the LEP Based on Subsequent Part D IEPs"*).

Plans must notify the beneficiary of any adjustment to the beneficiary's LEP as the result of a reconsideration by CMS' independent review entity. Plans may use the *Exhibit 7: Model Notice—Confirm Adjustment of Premium Based on Reconsideration of Late Enrollment Penalty* or create their own form using the requisite elements shown in the model, subject to CMS' marketing review procedures. The plan must then issue a refund to the member or credit the beneficiary's future premium bills to reflect the adjustment. Beneficiaries in premium withhold status will see a refund in a future Social Security check, once the change transaction has been submitted by the plan, processed by CMS, and sent to the Social Security Administration.

Please note that, in limited circumstances, a plan may have to remove or adjust an LEP imposed on a member who has since disenrolled from the plan. The plan will still need to take the actions describe above, and ensure that the code 72 (Plan Change) transaction has the same effective date as the initial transaction that imposed the penalty.

Creditable Coverage Period Determinations for Low-Income Subsidy (LIS) Eligibles

As described in our September 27, 2007 memorandum, "Elimination of 2008 Late Enrollment Penalty for Low-Income Subsidy Eligible Beneficiaries," Medicare beneficiaries who qualify for LIS may enroll in a Medicare prescription drug plan through December 31, 2008, with no penalty. As long as these individuals remain continuously enrolled in Medicare Part D, they will not incur an LEP, and any uncovered months in 2006, 2007, and 2008 will not be a factor in determining any LEP, should they incur a break in coverage in the future. Thus, plans should not report uncovered months for any new enrollee who is LIS eligible at the time s/he makes the enrollment request or at the time that the enrollment becomes effective. Consider the following example:

> Mrs. Jones was LIS eligible through December 31, 2007 and submitted an enrollment request during the Annual Election Period, which began November 15, 2007. She is not subject to the LEP, even though she lost LIS effective January 1, 2008, when the enrollment was effective.

Beneficiaries who are dually eligible, i.e., eligible for Medicare and Puerto Rico's Medicaid plan, known as Reforma, are exempt from the LEP in the same manner as those who are LIS eligible in the States.

Note: The guidance provided in both the above-referenced memo and this memo supersedes existing guidance at Section 10.2.3 of Chapter 4.

Cessation of the LEP Due to LIS Eligibility

If a beneficiary who is currently paying an LEP becomes LIS eligible, the penalty is removed effective with the start of LIS eligibility. (Please note that the beneficiary is responsible for any unpaid LEP amount owed prior to the LIS eligibility effective date). Plans are responsible for reviewing the appropriate CMS reports that include updated information about members' LIS status and must submit a change transaction to CMS that resets the LEP amount to zero. To accomplish this, plans will submit a Plan Change transaction (code 72) with the creditable coverage flag set to "R" and the number of uncovered months equal to zero ("0") with the effective date equal to the effective date of the individual's LIS eligibility. Plans must notify the LIS eligible member of the removal of the LEP and shall use either *Exhibit 5: Model Letter Informing Beneficiary of the Removal of the LEP Due to LIS Eligibility*) or create their own form using the requisite elements shown in the model, subject to CMS' marketing review procedures.

Plans must send this notice within 14 days of receiving information about the member's LIS status from CMS, and, for members in direct bill status, either issue a refund of any LEP paid since the member became LIS eligible or apply the amount to be refunded to a future premium bill. Those in premium withhold status will receive a refund in their Social Security check.

Consider the following example:

> Mrs. Robinson enrolled in Part D for the first time effective January 1, 2007. Since her IEP ended on May 15, 2006, and because she had no other creditable coverage prior to enrolling in Part D, she had 7 uncovered months, and has therefore been charged an LEP. She became LIS eligible effective July 1, 2007, and her plan was notified of this change in the CMS plan reports released at the end of July. The plan submits an Plan Change transaction code (code 72) with the creditable coverage flag value set to "R" and the number of uncovered months value set to "0" effective as of July 1, 2007 resetting her LEP to zero, and notifies her accordingly. Her uncovered months in 2006 will not be counted in the future if she later incurs a break in coverage. (Note: To "reset" means to end an existing period of time subject to an LEP and begin a new period.)

In the event that the beneficiary loses LIS eligibility after enrolling in a Part D plan, there is no imposition of an LEP, even if there are prior uncovered months. In the above example, if Mrs. Robinson had subsequently lost her LIS eligibility at some point in 2008, she would not incur an LEP as long as she incurs no future break in creditable coverage. If she ever does incur a break in coverage, none of the months prior to her January 1, 2007 enrollment would count as uncovered months.

Enrollees in the Program of All-Inclusive Care For the Elderly (PACE)

As stated in the introduction to Chapter 4 of the Prescription Drug Manual, PACE organizations offering prescription drug plans also are responsible for determining at the time of enrollment whether a beneficiary was previously enrolled in Part D or had other creditable coverage prior to enrolling in their plan, and are required to report any lapses in coverage of 63 days or more to CMS. However, PACE enrollees who are dual-eligible members are not subject to the LEP, as long as they remain enrolled in Part D. (Please see our memorandum of September 27, 2007, described above.) Therefore, PACE organizations do not need to collect information concerning uncovered months from these individuals or send these individuals an attestation forms. Rather, the organization is required to complete the creditable coverage period determination only for its Medicare-only members. In the event that, while the plan is conducting such a determination, the member also becomes eligible for Medicaid, then the organization would suspend its determination. If the organization has already submitted uncovered months to CMS, the organization would then submit a change transaction with the creditable coverage flag set to "R" to reset the amount to zero, as described above for new LIS eligibles.

Reporting Adjustments to the LEP Based on Subsequent Part D IEPs

As stated in current guidance (Section 10.1.1 of Chapter 4), an individual who becomes eligible for Medicare prior to turning age 65 (e.g., due to disability) will have a new IEP upon becoming entitled to Medicare due to age (i.e., turning 65). Plans should already have in place a process for identifying members who are attaining age 65, or who have recently attained age 65. They will also need to take the following actions described below, depending on the specific situation.

- For individuals who are currently enrolled in a Medicare prescription drug plan at the start of their second Part D IEP, the LEP ends on the day before the second IEP begins, which is three months prior to the month the individual attains age 65. So, for example, if a beneficiary turns 65 on July 25, 2008, his/her LEP would end effective March 31, 2008. Any uncovered periods prior to that date are no longer counted for purposes of the LEP. The plan must reset the number of uncovered months to zero ("0") by submitting a plan change transaction (code 72) with the creditable coverage flag set to "R" and the number of uncovered months equal to "0". The effective date of the transaction is equal to the first of the month of the new Part D IEP. So, in the example described above, the effective date of the change transaction would be April 1, 2008.
- For individuals who are not enrolled in a Medicare drug plan at the time of the second IEP, and who are still within that second IEP, the plan must reset the number of uncovered months to zero ("0") as part of the initial enrollment transaction, rather than a change transaction. As

described above, the creditable coverage flag is set to "R" and the number of uncovered months equal to "0".

- For individuals who did not enroll in a Medicare prescription drug plan by the end of their subsequent IEP, the plan will have to take actions to "reset" or remove the first LEP and provide any uncovered months incurred after the subsequent IEP so that a second LEP can be imposed. The plan must reset the first LEP by submitting a change transaction as described above, with the effective date equal to the end date of the previous Part D plan enrollment. Then, the plan shall submit a change transaction with the creditable coverage flag set to "N" and the number of uncovered months. The effective date of the transaction is equal to the current enrollment effective date.

Plans must notify the member of the removal of the LEP and may *Exhibit 4: Model Notice--Removal of Late Enrollment Penalty Due to Subsequent IEP* to inform beneficiaries of the removal of the LEP or create their own form using the requisite elements shown in the model, subject to CMS' marketing review procedures.

Billing the Late Enrollment Penalty

Once plans receive information from CMS about the amount of the beneficiary's LEP, they are expected to bill and recoup any LEP amount owed since the beneficiary's enrollment effective date but no earlier than January 1, 2007. For those in direct bill status, the plan may retroactively bill the member for a lump sum amount. Plans may use *Exhibit 2: Model Notice—Beneficiary Notice of Late Enrollment Penalty* to reflect this possible billing option, or create their own form using the requisite elements shown in the model, subject to CMS' marketing review procedures. For those beneficiaries whose premium is withheld from their Social Security check, plans do not need to bill these beneficiaries for either prospective or retroactive amounts. (See Section 40.3 of Chapter 4.)

Annual Changes in LEP Amounts

At the start of each calendar year, the LEP amount will change based on the national base beneficiary premium. While there is no Transaction Reply Code (TRC) associated with this change, plans will see the adjustment in the December LIS/LEP Report (for members in direct bill status) for January 1st plan payment and the January Monthly Premium Withhold Report (for those in premium withhold status) for February 1st plan payment. These reports will be released in accordance with the reports schedule contained in the Plan Communications User Guide. Plans will need to adjust their bills accordingly to reflect the new amount. Plans may include notification of this new amount in their premium bill, or via a separate notice. CMS has provided a new model for this purpose, *Exhibit 9: Model Notice—Yearly Change to LEP Amount*. Please note that the reconsideration process is not available for adjustments to the LEP based on a change to the new national base beneficiary premium. Therefore, plans **shall not** include an LEP Reconsideration Notice or Reconsideration Request Form with notice of the adjusted LEP.

LEP for New Members

With respect to those members who currently owe an LEP and change plans, the new plan will be able to see in the BEQ response file or the Common UI the total number of uncovered months associated with the beneficiary's previous enrollment. The plan will know that the beneficiary owes a LEP and must remind the member in the enrollment confirmation notice that the premium owed includes this LEP amount. CMS has provided the following model language, which can be inserted into the model enrollment confirmation notices included in the appropriate CMS Guidance for your plan type:

> 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 <*toll-free number*> <*days and hours of operation*>. TTY users should call <*toll-free TTY number*>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Thank you.

Provided the new plan is not reporting additional uncovered months, this notification does not constitute an imposition of a new LEP or an increase in the previous LEP and therefore does **not** trigger the right to request a review of the LEP. Thus, plans **shall not** include an LEP Reconsideration Notice or Reconsideration Request Form with the enrollment confirmation notice (as modified above) for new members who previously owed and continue to owe an LEP. Plans are not required to provide additional information about an existing LEP but, if they choose to do so, they may use *Exhibit 3: Model Notice—Beneficiary Notice of Existing Late Enrollment Penalty.*

Reports from CMS

We are revising information provided at section 40.2 of Chapter 4 about CMS reports that contain beneficiary-specific information about the LEP, as shown below:

PCUG Appendix*	Name of Data File/Report	Availability
E91	Weekly Transaction Reply Report (only includes beneficiaries for whom a transaction was submitted during the prior week)	Weekly
E91	Monthly Transaction Reply Report (only includes beneficiaries for whom a transaction was submitted during the prior month)	Monthly
E105	Low-Income Subsidy/Late Enrollment Penalty (LIS/LEP) Data File (direct bill beneficiaries only)	Monthly
E59	Monthly Premium Withholding Report Data File (beneficiaries in premium withhold status only)	Monthly

*Please refer to the current CMS Plan Communications User Guide (Version 3.0).

Please note: As stated in section 30.1 of Chapter 4, plans are required to notify members of the imposition of, or adjustment to, an LEP in writing within 10 calendar days of receiving notice of the LEP from CMS. Notice from CMS constitutes the first report from CMS that contains this information. The monthly and weekly TRRs will only contain information for a member if a transaction was submitted for that member the previous week or month. Thus, if information is not available in either of those reports, but instead through the LIS/LEP report (for members in direct bill status) or the Monthly Premium Withhold Report (for those in premium withhold status), the plan would have 10 days from the receipt of either of these reports, as appropriate, to send the notice of the LEP.

New and Revised Appendices and Exhibits

The following exhibits have been added or revised, as described further below, and are attached to this memorandum. Marketing codes are inserted below so that plans can use these notices as "file and use."

NOTE: Marketing codes for LEP exhibits listed in Chapter 4 can be found in HPMS. (HPMS code #8002 is no longer in use).

Chapter 4

Please note that the Exhibit numbers have changed from what exists in Chapter 4.

Appendix 1: Special Opportunity to Enroll in 2006, 2007, and 2008
This Appendix has been updated to reflect the extension of the demonstration for low-income subsidy eligible beneficiaries through December 31, 2008.

NEW Appendix 2: Summary of MARx Transactions to Add, Change, or Remove the Number of Uncovered Months for an Enrolled Beneficiary

Exhibit 1A: Model Notice for Beneficiary Attestation of Creditable Prescription Drug Coverage [HPMS code: 8001]

The following changes were made to the Attestation Form:

- Updated dates to include new contract year, 2008.
- Clarified that the term "PACE organization" refers to the Program of All-Inclusive Care for the Elderly.
- Optional language has been inserted so that plans can customize references to a state's Medicaid program or SPAP, where applicable.

NEW Exhibit 1B: Model Notice for Beneficiary Attestation of Creditable Prescription Drug Coverage—FINAL NOTICE [HPMS code: 8001]

Exhibit 2: Model Notice—Beneficiary Notice of Late Enrollment Penalty [HPMS code 8003]

The following changes were made to this notice:

- Added language after the first sentence applicable to beneficiaries in premium withhold.
- Added language in second paragraph for beneficiaries who owe a "lump sum" amount retroactive to the date of their enrollment in the plan.
- Modified language to reflect change to LEP Reconsideration Request Form.
- Modified optional language for employer/unions to also include State Pharmaceutical Assistance Programs (SPAPs), as these organizations can attest to their members' coverage, as described above.
- Provided optional language so that the notice can be used for beneficiaries who are enrolling in the Part D prescription drug program for the first time, as well as those who have incurred an additional LEP since prior plan enrollment.

NEW Exhibit 3: Model Notice—Beneficiary Notice of Existing Late Enrollment Penalty [HPMS code: 8008]

This new model notice is sent to inform beneficiaries of an existing LEP. This notice does not include information concerning a beneficiary's right to appeal. (Please see section above entitled, "LEP for New Members".)

NEW Exhibit 4: Model Notice—Removal of Late Enrollment Penalty Due to Subsequent IEP [HPMS code: 8009]

This new model notice is sent to beneficiaries whose LEP is being removed because they obtained a second IEP based on turning age 65. (Please see section above entitled, "Reporting Adjustments to the LEP Based on Subsequent IEPs".)

NEW Exhibit 5: Model Letter—Removal of the LEP Due to LIS Eligibility [HPMS code 8010]

This new model notice is sent to beneficiaries whose LEP is being removed due to their attaining LIS eligibility. (Please see section above entitled, "Removal of the LEP Due to LIS Eligibility".)

NEW Exhibit 6: Model Notice—LEP Adjustment Due To Plan Error [HPMS code: 8011]

This new model notice is sent to beneficiaries whose LEP has been adjusted because the plan has corrected an error in the number of uncovered months reported to CMS, transmission, etc. (Please see section above entitled, "Corrections to Reports of Creditable Coverage Period Determinations".)

Exhibit 7: Model Notice—Confirm Adjustment of Premium After Reconsideration of Late Enrollment Penalty [HPMS code: 8004]

This revised model notice is sent to inform a beneficiary of the adjusted amount of his/her LEP as a result of the LEP reconsideration decision. (Please see section above entitled, "LEP Reconsideration Process".)

Exhibit 8: Model Notice—Return of Creditable Coverage Information Received Without an Accompanying Enrollment Request [HPMS code: 8005]

This revised model notice was revised to incorporate minor editorial changes.

OLD Exhibit 9: Model Notice—Creditable Coverage Information Received After Deadline Date

Since plans are now required to submit corrections when they receive a late attestation form, this notice is no longer needed and has been removed. (Please see section above entitled, "Corrections to Reports of Creditable Coverage Period Determinations".)

NEW Exhibit 9: Model Notice—Yearly Change to LEP Amount [HPMS code: 8012]

This new model notice is sent to beneficiaries to inform them of the change in their LEP amount for the upcoming year due to the adjustment of the National Base Beneficiary Premium. (Please see the section above entitled, "LEP and the National Base Beneficiary Premium".)

NOTE: In conjunction with our revised policy that requires plans to submit corrections when they receive a late attestation, we have deleted the Model Notice—Creditable Coverage Information Received After Deadline Date. (Please see the section above entitled, "Corrections to Reports of Creditable Coverage Period Determinations".)

Chapter 18

Appendix 14 – Model Part D Late Enrollment Penalty Reconsideration Notice [HPMS code: 8006]

This notice has been modified to clarify the reasons enrollees may file for LEP reconsideration, as described further above in the section, "LEP Reconsideration Process." Also, the formatting of this notice has been made consistent with the Model Attestation Form (Chapter 4, Exhibit 1A) and Model LEP Reconsideration Request Form (see below).

Appendix 15 – Model Part D Late Enrollment Penalty Reconsideration Request Form [HPMS code: 8007]

The Model LEP Reconsideration Request Form has been revised to solicit additional information about prior drug coverage and to clarify the specific reasons enrollees may request a reconsideration of their Part D LEP. Additionally, the reasons a beneficiary may file for reconsideration (i.e., the checkboxes) have been reordered for consistency with the Model Attestation Form (Chapter 4, Exhibit 1) and so that the most common reasons enrollees file for reconsideration appear earlier on the form. The formatting of this form also has been made consistent with the Model Attestation Form (Chapter 4, Exhibit 1) and Model LEP Reconsideration Notice.

Appendix 1: Special Opportunity to Enroll in 2006, 2007, and 2008 without LEP

Medicare beneficiaries who qualify for the low-income subsidy for Medicare prescription drug coverage may enroll in a Medicare prescription drug plan with no penalty through December 31, 2008. As long as these individuals stay continuously enrolled in a Medicare drug plan, they will not be assessed an LEP in 2006, 2007, 2008, or afterwards. If these individuals disenroll after 2008, and then have a continuous period of 63 days or more since the end of their IEP without creditable prescription drug coverage, they will incur an LEP upon re-enrollment into a Medicare drug plan; however, their uncovered months in 2006, 2007, and 2008 will not be a factor in the calculation of their LEP.

Certain Medicare beneficiaries who were affected by Hurricane Katrina were allowed to enroll in a Medicare prescription drug plan with no penalty through December 31, 2006. As long as these individuals stay continuously enrolled in a Medicare drug plan, they will not be assessed an LEP in 2006 or afterwards. If these individuals disenroll after 2006 and then have a continuous period of 63 days or more without creditable prescription drug coverage, they will incur an LEP upon re-enrollment into a Medicare drug plan; however, their uncovered months in 2006 will not be a factor in the calculation of their LEP.

Appendix 2: *Summary of MARx Transactions to Add, Change, or Remove the Number of Uncovered Months for an Enrolled Beneficiary

Action	Creditable Coverage Flag Value	Number of Uncovered Months Field Value	Effective Date on Transaction Code 72
Submit a new number of uncovered months	N	Number greater than 0	Equal to existing enrollment effective date *Note: This information may also be provided on an enrollment transaction (60/61/62/71),*
Change an existing number of uncovered months due to plan error or reconsideration decision	N	Revised number greater than 0	Equal to existing enrollment effective date
	Y	0	Equal to existing enrollment effective date
Reset the existing number of uncovered months to 0 due to another IEP for Part D	R	0	Equal to the effective date of the 1st month of the new IEP for Part D
Reset the existing number of uncovered months to 0 due to an individual becoming LIS eligible.	R	0	Equal to the effective date of the start of LIS eligibility.
Correct Erroneous Reset action already submitted	U	0	Effective date is equal to the date of the reset "R" transaction. (Page 5 of Fall Memo).

*For more information about MARx transactions, please consult the October 9, 2007 HPMS Memo re: *Announcement of Fall Software Changes* and the current CMS Plan Communications User Guide (Version 3.0).

Exhibit 1A: Model Notice for Beneficiary Attestation of Creditable Prescription Drug Coverage

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

Important:
Medicare Needs More Information from You

You recently enrolled in a plan and you may owe a penalty.

Do any of these statements apply to you for 2006, 2007, or 2008?

- I had drug coverage from an employer or union plan
- I had drug coverage from Medicaid, a State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state
- I had VA benefits
- I had TRICARE or other military drug coverage
- I had a Medigap policy with drug coverage
- I had drugs through the Indian Health Service or a tribal organization
- I had drug coverage through PACE (Program of All-Inclusive Care for the Elderly)
- I had drug coverage from a different source not listed here
- I have/had extra help from Medicare to pay for my drug coverage
- I lived in an area affected by Hurricane Katrina

If any of these circumstances apply, you may **not** owe a late enrollment penalty as part of your Medicare prescription drug plan premium.

What You Need to Do Now

Medicare needs more information from you to see if you will owe a penalty. <u>If you fail to respond, you will owe a penalty</u>. So, please fill out the "Beneficiary Attestation of Creditable Prescription Drug Coverage" form enclosed with this letter [*insert if plan offers telephonic attestation:* or call

your plan to provide them with additional information they need]. To avoid a late enrollment penalty, you must [*insert if plan offers telephonic attestation:* call or] send back the enclosed form by the date stated on the form. If you have questions, or if you aren't sure about the answers to the questions above, call your health plan at the telephone number listed on the form.

<Member ID #>

<Date>

<Name of Member>:

You recently enrolled in our plan and Medicare's records show that you may owe a late enrollment penalty.

[Insert the following if beneficiary was previously enrolled in a plan:]

You were first eligible to join a Medicare drug plan through <*insert last month of IEP in mm/yyyy format*>. From the time your enrollment ended with [insert one of the following: *us/your last plan*] until your current enrollment in our plan, you did not have Medicare prescription drug coverage or other coverage as good as Medicare's (creditable coverage) during the following period(s): *<INSERT PERIOD(S) HERE>*.

[OR insert the following:]
You were first eligible to join a Medicare drug plan through <*insert last month of IEP in mm/yyyy format*>. You did not have Medicare prescription drug coverage or other coverage as good as Medicare's (creditable coverage) during the following period(s): *<INSERT PERIOD(S) HERE>*.

Please complete this form and return it immediately to <*insert Plan Name*> at <*insert Plan Address*> [*insert the following if you offer telephone attestation:* or call us at <*insert Plan Toll-free Number*> to provide us with the information] by <*insert the date that is 30 days from the date of this letter in mm/dd/yyyy format*>.

If you don't contact us by <*insert the date that is 30 days from the date of this letter in mm/dd/yyyy format*>, we will assume the above information is correct and you will owe a late enrollment penalty.

Please check all boxes that apply to you.

☐ I had creditable prescription drug coverage from the source(s) listed below: ***(Give the date(s) of your coverage. Use another sheet if necessary).***

□ I had drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP)
Name: _____
from *(month/year)*: _____ to (*month/year)*:_____

□ I had drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state
from *(month/year)*:_____ to *month/year)*:_____
Name of SPAP:_____

If you are in an SPAP, what state do you live in:

___

□ I had VA benefits (veterans, survivor, or dependent benefits)
from *(month/year)*: _____ to *(month/year)*:_____

□ I had TRICARE or other military coverage
from *(month/year)*: _____ to *(month/year)*:_____

□ I had a Medigap (Medicare Supplemental) policy with drug coverage
from *(month/year)*: _____ to *(month/year)*:_____

□ I had drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U)
from (*month/year)*: _____ to *month/year)*:_____

□ I had drug coverage through PACE (Program of All-Inclusive Care for the Elderly) from *(month/year)*: _____
to (*month/year)*:_____

□ I had drug coverage from a different source not listed above.
Name of other source: _____
from (*month/year*):_____ to: (*month/year*):_____

□ I have/had extra help from Medicare to pay for my prescription drug coverage. Date(s) of extra help: from (*month/year*):_____ to: (*month/year*):_____

□ I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare drug plan before December 31, 2006.
Name of Parish: _____

☐ I never had creditable drug coverage.

Please complete this section: "I attest (promise) that the information on this form is true and correct to the best of my knowledge. I understand that if I didn't have creditable prescription drug coverage and/or don't give proof of creditable drug coverage if asked, my premium may be higher.

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 document means that I have read and understand the contents of this attestation. 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:_____

Date: *(month/day/year):* _____

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

Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone Number: (_____) _____- _____

Relationship to Enrollee: _____

Contact Information

If you have questions about the information in this form, the late enrollment penalty, [*insert the following if you provide the telephone attestation option:* or would like to complete this form over the telephone,] call <*Plan Name*> at <*toll-free number*> <*days and hours of operation*>. TTY users should call <*toll-free TTY number*>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Exhibit 1B: Model Notice for Beneficiary Attestation of Creditable Prescription Drug Coverage

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FINAL NOTICE
YOUR IMMEDIATE RESPONSE IS REQUESTED

You recently enrolled in a plan and you may owe a penalty.

Do any of these statements apply to you for 2006, 2007, or 2008?

- I had drug coverage from an employer or union plan
- I had drug coverage from Medicaid, a State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state
- I had VA benefits
- I had TRICARE or other military drug coverage
- I had a Medigap policy with drug coverage
- I had drugs through the Indian Health Service or a tribal organization
- I had drug coverage through PACE (Program of All-Inclusive Care for the Elderly)
- I had drug coverage from a different source not listed here
- I have/had extra help from Medicare to pay for my drug coverage
- I lived in an area affected by Hurricane Katrina

If any of these circumstances apply, you may **not** owe a late enrollment penalty as part of your Medicare prescription drug plan premium.

What You Need to Do Now

Medicare needs more information from you to see if you will owe a penalty. If you fail to respond, you will owe a penalty. So, please fill out the "Beneficiary Attestation of Creditable Prescription Drug Coverage" form enclosed with this letter [*insert if plan offers telephonic attestation:* or call

your plan to provide them with additional information they need]. To avoid a late enrollment penalty, you must [*insert if plan offers telephonic attestation:* call or] send back the enclosed form by the date stated on the form. If you have questions, or if you aren't sure about the answers to the questions above, call your health plan at the telephone number listed on the form.

<Member ID #>

<Date>

<Name of Member>:

You recently enrolled in our plan and Medicare's records show that you may owe a late enrollment penalty.

[Insert the following if beneficiary was previously enrolled in a plan:]

You were first eligible to join a Medicare drug plan through <*insert last month of IEP in mm/yyyy format*>. From the time your enrollment ended with [insert one of the following: *us/your last plan*] until your current enrollment in our plan, you did not have Medicare prescription drug coverage or other coverage as good as Medicare's (creditable coverage) during the following period(s): *<INSERT PERIOD(S) HERE>*.

[OR insert the following:]
You were first eligible to join a Medicare drug plan through <*insert last month of IEP in mm/yyyy format*>. You did not have Medicare prescription drug coverage or other coverage as good as Medicare's (creditable coverage) during the following period(s): *<INSERT PERIOD(S) HERE>*.

Please complete this form and return it immediately to <*insert Plan Name*> at <*insert Plan Address*> [*insert the following if you offer telephone attestation:* or call us at <*insert Plan Toll-free Number*> to provide us with the information] by <*insert the date that is 30 days from the date of this letter in mm/dd/yyyy format*>.

If you don't contact us by <*insert the date that is 30 days from the date of this letter in mm/dd/yyyy format*>, we will assume the above information is correct and you will owe a late enrollment penalty.

Please check all boxes that apply to you.

☐ I had creditable prescription drug coverage from the source(s) listed below: ***(Give the date(s) of your coverage. Use another sheet if necessary).***

□ I had drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP)
Name: _____
from *(month/year)*: _____ to *(month/year)*: _____

□ I had drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state
from *(month/year)*: _____ to *month/year)*: _____
Name of SPAP: _____

If you are in a SPAP, what state do you live in:

_____

□ I had VA benefits (veterans, survivor, or dependent benefits)
from *(month/year)*: _____ to *(month/year)*: _____

□ I had TRICARE or other military coverage
from *(month/year)*: _____ to *(month/year)*: _____

□ I had a Medigap (Medicare Supplemental) policy with drug coverage
from *(month/year)*: _____ to (*month/year)*: _____

□ I had drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U)
from (*month/year)*: _____ to *month/year)*: _____

□ I had drug coverage through PACE (Program of All-Inclusive Care for the Elderly) from *(month/year)*: _____
to (*month/year)*: _____

□ I had drug coverage from a different source not listed above.
Name of other source: _____
from (*month/year*): _____ to: (*month/year*): _____

□ I have/had extra help from Medicare to pay for my prescription drug coverage. Date(s) of extra help: from (*month/year*): _____ to: (*month/year*): _____

□ I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare drug plan before December 31, 2006.
Name of Parish: _____

☐ I never had creditable drug coverage.

Please complete this section: "I attest (promise) that the information on this form is true and correct to the best of my knowledge. I understand that if I didn't have creditable prescription drug coverage and/or don't give proof of creditable drug coverage if asked, my premium may be higher.

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 document means that I have read and understand the contents of this attestation. 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:_____

Date: *(month/day/year):* _____

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

Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone Number: (_____) _____- _____

Relationship to Enrollee: _____

Contact Information

If you have questions about the information in this form, the late enrollment penalty, [*insert the following if you provide the telephone attestation option:* or would like to complete this form over the telephone,] call <*Plan Name*> at <*toll-free number*> <*days and hours of operation*>. TTY users should call <*toll-free TTY number*>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Exhibit 2: Model Notice
Beneficiary Notice of Late Enrollment Penalty

<Date>

Dear <Name of Member>:

We are writing to tell you that starting <*effective date*>, your new premium will be <*amount of new premium*> per month. Your new premium amount includes an additional <*LEP amount*> each month because you didn't have Medicare prescription drug coverage or other drug coverage as good as Medicare's (creditable coverage).

[*Insert the following if the beneficiary is enrolling in a Part D plan for the first time:]*
According to Medicare's records, you did not have creditable coverage for <*# of uncovered months*> from <*date*> *to* <*date*> after you were first eligible to sign up for Medicare prescription drug coverage.

[OR insert the following if the beneficiary was previously enrolled in a Part D prescription drug plan:]
According to Medicare's records, you did not have creditable coverage for <*# of uncovered months*> from <*effective date of disenrollment from previous plan*> to <*the month before the effective date in your plan*>.

[*Insert the following if the beneficiary's LEP amount has to be paid retroactively:]*
Since you owe a late enrollment penalty dating back to your effective date of enrollment, we will charge you a lump sum amount of <*amount of lump sum owed retroactive to the date of their enrollment in the plan*>. After this one time lump sum payment, you will be charged <*amount of new premium*> per month. [*For members in direct-bill status, insert the following language:]* Your premium bill will reflect this new premium amount. *[For members in premium withhold status, insert the following language]:* This lump sum amount will be deducted from your Social Security check. After this, your new premium amount will also be deducted from your monthly Social Security check.

[Insert the following if employer, union, or State Pharmaceutical Assistance Program is paying the LEP amount on behalf of member:]

<*Name of employer or union sponsoring the Plan*> has agreed to pay <*LEP amount*>, the amount of your late enrollment penalty, on your behalf. If your coverage is terminated by you or <*name of employer or union sponsoring the Plan*>, or if <*name of employer or union sponsoring the Plan*> stops paying your late enrollment penalty, you will be responsible for paying that amount.

If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision if certain circumstances apply to you. (For example, you might disagree with the penalty if you had extra help from Medicare to pay for your prescription drug coverage in 2006, 2007, and/or 2008; or if you did not receive notice that explained whether you had creditable coverage). A notice explaining your right to a reconsideration of the late enrollment penalty is included with this letter. You must submit your reconsideration request within 60 days of the date of this letter, or Medicare may not consider your request.

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

Thank you.

Exhibit 3: Model Notice
Beneficiary Notice of Existing Late Enrollment Penalty

<Date>

Dear <Name of Member>:

We are writing to tell you that starting <*effective date*>, your premium will be <*amount of premium*> per month. This amount is based on an existing late enrollment penalty that you were charged by your previous plan(s) because you did not have Medicare prescription drug coverage or other drug coverage as good as Medicare's (creditable coverage) for a total of <*insert total # of uncovered months that resulted in the existing LEP*>.

[*Insert the following if the beneficiary's LEP amount has to be paid retroactively:]* Since you owe a late enrollment penalty dating back to your effective date of enrollment, we will charge you a lump sum amount of <a*mount of lump sum owed retroactive to the date of their enrollment in the plan*>. After this one time lump sum payment, you will be charged <a*mount of premium*> per month. [*For members in direct-bill status, insert the following language:]* Your premium bill will reflect this new premium amount. *[For members in premium withhold status, insert the following language]:* This lump sum amount will be deducted from your Social Security check. After this, your new premium amount will also be deducted from your monthly Social Security check.

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

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

Exhibit 4: Model Notice
Removal of Late Enrollment Penalty Due to Subsequent IEP

<Date>

Dear <Name of Member>:

We are writing to inform you that beginning <*effective date of new IEP*> you will no longer owe a late enrollment penalty each month. This means that your monthly premium will be reduced by <*insert amount of LEP*>. Your new monthly premium will be <i*nsert amount of premium minus LEP*>.

You will no longer owe an LEP because the late enrollment penalty is removed when a beneficiary enters Initial Enrollment Period for Part D (Part D IEP), and Medicare's records show that you <have>/<had> another Part D IEP based on your turning age 65. Your new IEP began/begins <*insert first month of new IEP*> and ends <*insert last month of new IEP*>. As long as you have Medicare prescription drug coverage or other creditable prescription drug coverage (as good as Medicare's) after the end of this Part D IEP, you will not be charged a late enrollment penalty.

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

Thank you.

Exhibit 5: Model Letter – Informing Beneficiary of the Removal of the LEP Due to LIS Eligibility

<Date>

Dear <Name of Member>:

We are writing to inform you that your monthly premium will no longer include the late enrollment penalty amount that you have been charged.

You will no longer owe a late enrollment penalty because our records show that effective <*effective date of LIS eligibility*> you were receiving extra help from Medicare to pay for your prescription drug coverage. This means that your monthly premium will be reduced by <i*nsert amount of LEP*>. Therefore, your new premium amount will be <*new premium amount*>.

[*For members in direct-bill status, insert the following language:]*
This also means any late enrollment penalty amount that you've paid since <effective date of LIS eligibility> [*Select method of LEP refund*:] *will be refunded back to you as soon as possible OR will be applied to reduce your next bill.* We will [*Select method of LEP refund:] refund you /reduce your next bill by <total LEP amount since the effective date of LIS eligibility*>. However, if you owe a late enrollment penalty prior to <*effective date of LIS eligibility*> you are responsible for paying that amount.

[OR insert the following for members in premium-withhold status:]
This also means that any late enrollment penalty amount that you've paid since <*effective date of LIS eligibility*> will be refunded to you by the Social Security Administration. The Social Security Administration will refund you <*total LEP amount since the effective date of LIS eligibility*> as soon as possible. However, if you owe a late enrollment penalty prior to <*effective date of LIS eligibility*> you are responsible for paying that amount.

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

Exhibit 6: Model Notice Informing Beneficiary of LEP Adjustment Due To Plan Error

<Date>

Dear <Name of Member>:

We are writing to tell you that starting <*effective date*>, your new premium will be <*amount of new premium*> per month. This new amount is due to <*insert the reason, e.g., erroneous calculation of number of uncovered months or error in transmitting that information to CMS*>.

[Insert the following if the error imposes or increases the amount of the LEP amount:] As a result of this error, the above premium amount includes a new LEP amount of <*new LEP amount*>. *[Insert the following if the error causes a beneficiary to owe a retroactive amount due to the error:]* This also means that you owe a previous late enrollment penalty of <*amount of retroactive LEP amount owed as a result of error*>.

[Insert the following if the beneficiary's LEP amount has to be paid retroactively:] Since you owe a late enrollment penalty dating back to your effective date of enrollment, we will charge you a lump sum amount of <*amount of lump sum owed retroactive to the date of their enrollment in the plan*>. After this one time lump sum payment, you will be charged <*amount of new premium*> per month. [*For members in direct-bill status, insert the following language:]* Your premium bill will reflect this new premium amount. *[For members in premium withhold status, insert the following language]:* This lump sum amount will be deducted from your Social Security check. After this, your new premium amount will also be deducted from your monthly Social Security check.

[OR insert the following if the error reduces the LEP amount:]
Because of this error, your new late enrollment penalty amount has been reduced. Your new late enrollment penalty amount is <*new LEP amount*>. *[For members in direct bill status, insert the following language:]* This also means that any late enrollment penalty amount that you've paid as a result of this error [S*elect method of LEP refund:] will be refunded back to you as soon as possible OR will be applied to reduce your next bill*. We will [Select method of LEP refund*:] refund you /reduce your next bill by <total LEP amount owed to the beneficiary*>. *[For*

members in premium-withhold status, insert the following language:] This also means that any late enrollment penalty amount that you've paid as a result of this error will be refunded to you by the Social Security Administration. The Social Security Administration will refund you <total LEP amount owed to the beneficiary> as soon as possible.

[Insert the following only if the error resulted in the imposition of or increase in LEP:] If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision if certain circumstances apply to you. (For example, you might disagree with the penalty if you were affected by Hurricane Katrina or if you got/get extra help from Medicare to pay for your prescription drug coverage in 2006, 2007, and/or 2008 if you did not receive notice that explained whether you had other prescription drug coverage as good as Medicare's (creditable coverage). A notice explaining your right to a reconsideration of the late enrollment penalty is included with this letter. You must submit your reconsideration request within 60 days of the date of this letter, or Medicare may not consider your request.

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

Thank you.

Exhibit 7: Model Notice
Confirm Adjustment of Premium After Reconsideration of Late Enrollment Penalty

<Date>

Dear <Name of Member>:

We are writing to let you know that your premium amount has been adjusted based on Medicare's decision about your late enrollment penalty. Starting <*effective date*>, your premium amount will be <*premium amount*> per month.

[Insert the following if the premium still includes an LEP:]
This amount includes a late enrollment penalty because Medicare wasn't able to confirm you had creditable prescription drug coverage (as good as Medicare's) for <# of uncovered months> months.

[Insert the following if the beneficiary's LEP amount has to be paid retroactively:]
Since you owe a late enrollment penalty dating back to your effective date of enrollment, we will charge you a lump sum amount of <*amount of lump sum owed retroactive to the date of their enrollment in the plan*>. After this one time lump sum payment, you will be charged <*amount of new premium*> per month. [*For members in direct-bill status, insert the following language:]* Your premium bill will reflect this new premium amount. *[For members in premium withhold status, insert the following language]:* This lump sum amount will be deducted from your Social Security check. After this, your new premium amount will also be deducted from your monthly Social Security check.

[OR insert the following if the premium no longer includes an LEP:]
This amount does not include a late enrollment penalty because Medicare decided you had other drug coverage as good as Medicare's (creditable coverage) and so you are not required to pay any additional amount. Any late enrollment penalty you have already paid *[Select method of LEP refund:] will be refunded to you as soon as possible OR will be applied to reduce your next bill*. Medicare's decision about your late enrollment penalty is not subject to further review.

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

Exhibit 8: Model Notice
Return of Creditable Coverage Information Received Without an Accompanying Enrollment Request

<Date>

Dear <Name of Beneficiary>:

We received information from you that showed you had other prescription drug coverage as good as Medicare's (creditable coverage), but our records don't show that you have applied to join <*Plan Name*>. Since we don't have an application from you to join our plan, we are returning your creditable coverage information to you. If you want to join <*Plan Name*>, please call us at <*toll-free number*> <*days and hours of operation*>. TTY users should call <*toll-free TTY number*>.

We may need you to send us another application. After we get your application, we will let you know if we need you to send us creditable coverage information. Remember, if you don't keep Medicare prescription drug coverage or other creditable coverage after you are eligible to join a Medicare drug plan, you may have to pay a late enrollment penalty for each month you were eligible to join but didn't. You will then have to pay the penalty as long as you have Medicare prescription drug coverage.

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

Thank you.

Exhibit 9: Model Notice
Yearly Change to LEP Amount

<Date>

Dear <Name of Member>:

We are writing to tell you that starting <*January 1, yyyy*>, your new premium will be <*amount of new premium*> per month.

This new amount is a change to your current late enrollment penalty amount based on the annual change to the National Base Beneficiary Premium. Each year the National Base Beneficiary Premium changes, so will the amount of your late enrollment penalty.

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

Thank you.

Chapter 18, Appendix 14 – Model Part D Late Enrollment Penalty Reconsideration Notice (Rev. 2, 04-11-08)

YOUR RIGHT TO ASK MEDICARE TO REVIEW YOUR MEDICARE PART D LATE ENROLLMENT PENALTY

What if I Don't Agree with Medicare's Late Enrollment Penalty Decision?
If you don't join a Medicare drug plan when you are first eligible, and you don't have other prescription drug coverage as good as Medicare's (creditable coverage), you may have to pay a late enrollment penalty (LEP). In some cases you have the right to ask Medicare to review your late enrollment penalty decision. This is called a "reconsideration." There are several reasons you could ask Medicare for a reconsideration – for example, if you think Medicare did not count all of your creditable drug coverage or if you didn't get a notice that clearly explained whether your previous prescription drug coverage was creditable. Other reasons for requesting a reconsideration are listed on the request form sent with this notice.

Who Can Ask for a Reconsideration?
You or someone you name to act for you (your representative) can ask for a reconsideration. If someone requests a reconsideration for you, proof must be sent with the reconsideration request form that the individual can represent you. Proof could be a power of attorney form, a court order, or an "Appointment of Representative" form. This last form can be found at http://www.medicare.gov/Basics/forms on the web. You also can call the Medicare helpline (see below) and ask for Form CMS-1696.

How Do I Ask for a Reconsideration?
The reconsideration request form is sent with this notice. Complete the form. Mail it to the address or fax it to the number listed on the form within 60 days from the date on the letter you got stating you have to pay a late enrollment penalty. You must also send proof that supports your case, like information about previous creditable prescription drug coverage. If you wait more than 60 days, you must explain why your request is late. Medicare will decide if you had good cause to send a late request.

What Do I Need to Include with My LEP Reconsideration Request?

1. A completed, signed LEP reconsideration request (keep a copy).
2. Copies of information you believe may help your case.
3. If you've named someone to act for you, a copy of the proof the individual can represent you.

NOTE: Do not send original documents.

Where Can I Get More Information?
Call <Plan Name> at <plan toll-free number> <days and hours of operation>. TTY users should call the plan at <plan TTY number>. *<A plan also may include a URL to its website here to provide additional information.>* Or, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for help. TTY users should call Medicare at 1-877-486-2048.

Chapter 18, Appendix 15 – Model Part D Late Enrollment Penalty Reconsideration Request Form (Rev. 2, 04-11-08)

LATE ENROLLMENT PENALTY RECONSIDERATION REQUEST FORM

Date: _____ **Enrollee Name**:_____

Address: _____

_____

Phone: (_____)_____

Medicare Health Insurance Claim #

(From red, white and blue Medicare card): _____

Name of Medicare Prescription Drug Plan: _____

IMPORTANT: Complete, sign and mail this request to the address or fax it to the number listed on the form within 60 days from the date on the letter you got stating you have to pay a late enrollment penalty. If it has been more than 60 days, explain your reason for delay on a separate sheet and send it with this form.

If applicable, please provide evidence of prior creditable prescription drug coverage. For example:

- **If you had drug coverage from an employer or union plan, provide a copy of the Notice of Creditable Prescription Drug Coverage or Certificate of Prior Creditable Prescription Drug Coverage from the employer or union plan.**
- **If you had drug coverage with the Department of Veterans Affairs (VA), please provide any of the following: Notice of Creditable Prescription Drug Coverage; a copy of your VA Health Benefit Card; a letter from the VA certifying eligibility; or an Explanation of Benefits (EOB).**

Check all boxes that apply to you (your case will only be reviewed for one or more of the following reasons):

☐ **I had other prescription drug coverage** as good as Medicare's (creditable coverage). Please complete the following (use a separate sheet, if necessary):

Plan Name: _____

Dates of coverage (mm/dd/yyyy) from _____/_____/_____ to _____/_____/_____

Plan Address & Phone: _____

Name of former employer/union/other insurer: _____

Contact name: _____ Phone: _____

☐ I had prescription drug coverage but **I didn't get a notice that clearly explained if my drug coverage was creditable** coverage.

Reminder: Most non-Medicare plans that offer prescription drug coverage, like employer or union coverage, must send enrollees a notice explaining how their prescription drug coverage compares to Medicare prescription drug coverage. Plans may provide this information in their benefits handbook or as a separate written notice.

If you don't know if your prescription drug coverage was creditable:

To help your case, you may want to send a letter to your previous plan and ask if your coverage was creditable. Attach your letter and any response to this form. You shouldn't wait to receive a response before you send this request form, and there is no need to send a letter if your prior coverage was with a Medicare drug plan.

☐ **I believe the LEP is wrong because I was not eligible to enroll in a Medicare drug plan during the period stated by my current Medicare drug plan.** Example: You lived outside of the United States during the initial enrollment period stated by your Medicare drug plan. You must submit proof why you believe the LEP is wrong, such as proof of overseas residency.

☐ **I believe the LEP is wrong because I was unable to enroll in a Medicare drug plan due to a serious medical emergency.** You must submit proof that you experienced a serious medical emergency (e.g., unexpected hospitalization) that affected your ability to enroll timely in a Medicare drug plan.

☐ **I have/had extra help from Medicare to pay for my prescription drug coverage.**
Date(s) of extra help: from _____to _____.
Use a separate sheet if necessary.

☐ **I lived in an area affected by Hurricane Katrina** at the time of the hurricane (August 2005) and I joined a Medicare drug plan before December 31, 2006.
Name of Parish: _____

By signing this form, I give permission to any entity to release information needed by Medicare to review my Medicare prescription drug late enrollment penalty.

_____ _____

Signature of Person Requesting Reconsideration (Either Enrollee or Representative) **Date**

I certify that the information on this form is true, accurate and complete. I understand that if I have submitted any false documents, made any false claims or statements, or concealed any material facts, I may be subject to civil or criminal liability.

Important: Prescription drug coverage is **insurance**. It's NOT doctor samples, discount cards/programs, free clinics, or drug discount websites.

Also, the "certificate of creditable coverage" that you may have received when your health coverage ended doesn't mean that your prescription drug coverage was as good as Medicare's standard prescription drug coverage – unless the notice specifically mentioned that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

Note about Representatives: If you want another individual, such as a family member, friend, or your doctor to request a reconsideration for you, that individual must be your representative. Contact your Medicare drug plan to learn how to name a representative.

Complete this section only if the person making this request is NOT the enrollee:

Representative Name:_____
Address:_____
Phone: (____) _____
Relationship to Enrollee: _____

Attach documentation that shows authority to represent enrollee, such as a Form CMS-1696.

Send this form and any extra pages to:

MAXIMUS (Medicare's Appeals Contractor)
<Plans: Insert appropriate address based on your plan type>

PDP Plans:
MAXIMUS
1040 First Avenue, Suite 200
King of Prussia, PA 19406
Fax: (484) 688-5601
Toll-free fax: (866) 589-5241

MA-PD Plans:
MAXIMUS
50 Square Drive, Suite 120
Victor, NY 14564
Fax: (585) 425-5301
Toll-free fax: (866) 825-9507

Be sure to include your Medicare Health Insurance Claim number on any materials you send. Do not send original documents.

Where Can I Get More Information? Call <Plan Name> at <plan toll-free number> <days and hours of operation>. TTY users should call the plan at <plan TTY number>. *<A plan also may include a URL to its website here to provide additional information.>* Or, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call Medicare at 1-877-486-2048. The list of parishes and counties that FEMA declared eligible for "individual assistance" as a result of Hurricane Katrina can be found at www.fema.gov/news/disasters.fema?year=2005

STOP! DID YOU SIGN THIS FORM?