# Part D Enrollment and Disenrollment Guidance Appendices and Exhibits

Updated August 2024

# Appendices

## Summary of
## Prescription Drug Plan Notice and
## Data Element Requirements

## Appendix 1: Summary of Notice Requirements

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

| Notice | Section | Timeframe |
|---|---|---|
| Medicare Prescription Drug Plan Individual Enrollment Form (Exh. 1) [1] | 40.1.1, 40.1.2 | N/A |
| Information to include on or with Enrollment Mechanism -- Attestation of Eligibility for an Enrollment Period (Exh. 1a) | 50.2 | N/A |
| Short Enrollment Form (Exh. 1b) | 40.1 | N/A |
| Model Plan Selection Form for Switch From Plan to Plan Within Parent Organization (Exh. 1c) | 40.1 | N/A |
| Acknowledge Receipt of Enrollment Request (Exh. 2) [2] | 50.9.1 | 10 calendar days of receipt of completed enrollment request |
| Acknowledge Receipt of Enrollment Request – Enrollment in another Plan Within the Same PDP Organization (Exh. 2a) | 50.9.1 | 10 calendar days of receipt of completed enrollment request |
| Acknowledge Receipt of Enrollment and Confirmation of Enrollment (Exh. 2b) [3] | 40, 50.9 | 7 calendar days of availability of DTRR |
| Request for Information (Exh. 3) | 30, 50.3 | N/A |
| Confirmation of Enrollment (Exh. 4) [4] | 30, 50.9.2 | 10 calendar days of availability of DTRR |
| Individuals Identified on CMS Records As Members of Employer/Union Receiving Employer Subsidy (Exh. 5) | 50.7 | 10 calendar days of availability of DTRR |

[1] Other CMS approved enrollment election mechanisms may take the place of an enrollment form
[2] Unless combine acknowledgment & confirmation notice, per section 50.9
[3] Required if the PDP sponsor has chosen to provide a single notice in response to the TRR, as described in section 50 and 50.9
[4] Required unless combined acknowledgment/confirmation notice is issued

| Notice | Section | Timeframe |
|---|---|---|
| PDP Organization Denial of Enrollment (Exh. 6) | 50.4, 50.6, 50.7 | 10 calendar days of receipt of enrollment request OR expiration of time frame for requested additional information |
| CMS Rejection of Enrollment (Exh. 7) | 30.3, 50.6, 50.9 | 10 calendar days of availability of TRR |
| Send Out Disenrollment Form/ Disenrollment Form (Exh. 8 – 9) | 60.1 | N/A |
| Information to include on or with Disenrollment Form -- Attestation of Eligibility for an Election Period (Exh. 9a) | 30.6, 60.1 | N/A |
| Acknowledgement of Receipt of Voluntary Disenrollment Request from Member (Exh. 10) | 60.1 | 10 calendar days of receipt of request to disenroll |
| Final Confirmation of Voluntary Disenrollment Identified Through DTRR (Exh. 10a) | 60.1 | 10 calendar days of availability of DTRR |
| Confirm Disenrollment Identified Through TRR – Reassigned LIS (Exh. 10b) | 40.1.9 | 10 calendar days of availability of DTRR |
| Confirmation of Disenrollment Due to Passive Enrollment into a Medicare- Medicaid Plan (Exh. 10c) | 60.1.1 | 10 calendar days of availability of DTRR |
| PDP Denial of Disenrollment (Exh. 11) | 60.1.1 | 10 calendar days of receipt of disenrollment request |
| Model Notice to Request Information (Disenrollment) (Exh. 11a) | 30, 60.1.2 | N/A |
| CMS Rejection of Disenrollment (Exh. 12) | 60.1.1 | 10 calendar days of availability of TRR |
| Disenrollment Due to Death (Exh. 13) | 60.2, 60.2.3 | 10 calendar days of availability of DTRR |
| PDP Model Notice for auto-enrollments provided by CMS with recent deceased code (Exh. 13a) | 40.1.8 | 10 calendar days of availability of DTRR |

| Notice | Section | Timeframe |
|---|---|---|
| Disenrollment Due to Loss of Medicare Part A and/or Part B (Exh. 14) | 60.2, 60.2.2 | 10 calendar days of availability of DTRR |
| Notices on Terminations/Nonrenewals[5] | Note | Follow requirements in 42 CFR 423.506 - 423.512 |
| Advanced Warning of Potential Disenrollment Due to Disruptive Behavior (no exhibit) | 60.3.2 | |
| Intent to request CMS' permission to disenroll the member (no exhibit) | 60.3.2 | |
| Confirmation of Disenrollment for Disruptive Behavior (no exhibit) | 60.3.2 | Before disenrollment transaction submitted to CMS |
| Disenrollment for Fraud & Abuse (no exhibit) | 60.3.3 | Before disenrollment transaction submitted to CMS |
| Offering Beneficiary Services, Pending Correction of Erroneous Death Status (Exh. 15) | 70.3, 70.3.1 | 10 calendar days of initial contact with member |
| Offering Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination (Exh. 16) | 70.3, 70.3.1 | 10 calendar days of initial contact with member |
| Offering Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to Plan Error (Exh. 17) | 70.3, 70.3.4 | 10 calendar days of initial contact with member |
| Closing Out Request for Reinstatement (Exh. 18) | 70.3 | 10 calendar days after information was due to organization |
| Failure to Pay Plan Premiums - Advance Notification of Disenrollment or Reduction in Coverage (Exh. 19) | 60.3.1 | Within 15 calendar days after the 1st of the month for which delinquent premiums due |
| Failure to Pay Plan Premiums - Notification of Involuntary Disenrollment (Exh. 20) | 60.3.1 | 3 business days following the last day of the grace period |

[5] Provided under separate CMS guidance

| Notice | Section | Timeframe |
|---|---|---|
| Failure to Pay Plan Premiums - Confirmation of Involuntary Disenrollment (Exh. 21) | 60.2.5, 60.3.1 | 10 calendar days of availability of DTRR |
| Involuntary Disenrollment by CMS for Failure to Pay Part D-IRMAA (Exh. 21a) | 60.2.5 | 10 calendar days of availability of DTRR |
| Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Premium Amount Due for Reinstatement (Exh. 21b) | 70.3.5 | 3 business days of receipt of CTM notification of favorable good cause determination |
| Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Premium Amount Due for Reinstatement (Exh 21c) | 70.3.5 | 3 business days following favorable good cause determination |
| Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (Exh 21d) | 70.3.5 | 3 business days following unfavorable good cause determination |
| Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment (Exh 21e) | 70.3.5 | 10 calendar days of the expiration of the 3 month period |
| Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement) (Exh 21f) | 70.3.5 | 3 business days following favorable good cause determination |
| Acknowledgement of Request to Cancel Enrollment (Exh. 22) | 70.2.1 | 10 calendar days of request |
| Confirmation of Reinstatement After Cancelling a Request to Enroll in Another Plan or Reinstatement for Favorable "Good Cause" Determination (Exh. 22a) | 70.2.1, 70.3.1, 70.3.3 | 10 calendar days of DTRR indicating reinstatement |
| Acknowledgement of Request to Cancel Disenrollment (Exh. 23) | 70.2.1 | 10 calendar days of request |

| Notice | Section | Timeframe |
|---|---|---|
| Inform member of Auto-enrollment (Exh. 24) | 40.1.8 | 10 calendar days of availability of DTRR or address report, whichever is later |
| Inform member of Facilitated Enrollment (Exh. 25) | 40.1.8 | 10 calendar days of availability of DTRR or address report, whichever is later |
| Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015) (Exh. 25b) | 70.2.3 | 10 calendar days of DTRR confirming cancellation |
| Request to Decline Part D (Exh. 26) | 40.1.8 | 10 calendar days of request |
| PDP Acknowledgement of Request to Disenroll from PDP and Opt-Out of Part D After Effective Date (Exh. 26a) | 40.1.8 | 10 calendar days of request |
| Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low- Income Premium Subsidy Amount for that Region (Exh. 27) | 60.2.1.4 | 10 calendar days of availability of DTRR |
| Auto and Facilitated Enrollees Who Permanently Reside in another Region Where PDP Sponsor Does Not offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region (Exh. 28) | 60.2.1.4 | 10 calendar days of confirmation that individual does not reside in region |
| Reassignment Confirmation (Exh. 29) | 40.1.9 | 10 calendar days of availability of DTRR |
| Optional Notice for "Losing Plan" to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC) (Exh. 30) | 40.1.9 | |
| Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes (Exh. 31) | N/A | 10 calendar days of availability of DTRR |

| Notice | Section | Timeframe |
|---|---|---|
| Model Employer/Union Group Enrollment Mechanism Notice (Exh. 32) | 40.1.10 | Minimum 21 calendar days prior to effective date of enrollment |
| Research Potential Out of Area Status (Exh. 33) | 60.2.1.3 | 10 calendar days of receipt of information indicating potential out-of-area status |
| Disenrollment Due Out of Area Status (No Response to Request for Address Verification) (Exh. 34) | 60.2.1.3 | Within the first ten calendar days of the 12th month |
| Disenrollment Due to Out of Area Status (Upon New Address Verification from Member) (Exh 35) | 60.2.1.3 | Within 10 calendar days of confirmation that out-of-area move was permanent |
| Notice of Involuntary Disenrollment by the CMS due to Incarceration (Exh. 36) | 60.2, 60.2.1.1 | 10 calendar days of notification on the DTRR |
| Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence (Exh. 37) | 60.2, 60.2.6 | 10 calendar days of notification on the DTRR |

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

All data elements with a "Yes" in the "Beneficiary response required on enrollment request" column are necessary in order for the enrollment election to be complete.

| | Data Element | Required on enrollment mechanism? | Response required on enrollment request? |
|---|---|---|---|
| 1 | PDP Plan name[6] | Yes | Yes |
| 2 | Beneficiary name | Yes | Yes |
| 3 | Beneficiary Birth Date | Yes | Yes |
| 4 | Beneficiary Sex | Yes | Yes |
| 5 | Beneficiary Telephone Number | Yes | No |
| 6 | Permanent Residence Address | Yes | Yes |
| 7 | Mailing Address | Yes | No |
| 8 | Name of person to contact in emergency, including phone number and relationship to beneficiary (Optional Field) | No | No |
| 9 | E-mail address | No | No |
| 10 | Beneficiary Medicare number | Yes | Yes |
| 11 | Additional Medicare information contained on Medicare card, or copy of card[7] | No | No[8] |
| 12 | Plan Premium Payment Option | No | No[9] |
| 13 | Other insurance COB information | No | No[10] |
| 14 | Long term care question | No | No |
| 15 | Beneficiary signature and/or Beneficiary Representative Signature | Yes | Yes[11] |

[6] If the enrollment mechanism will be used for multiple plans (PBPs), all plan names must be listed in a way that permits the applicant to clearly indicate their plan choice

[7] Plans may include the image of the Medicare card in enrollment mechanisms

[8] We recognize that the PDP needs, at a minimum, the Medicare number in order to verify entitlement to Part A and/or enrollment in Part B.

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

[10] Refer to CMS COB guidance for additional information

[11] Applicable only to requests made using a paper enrollment form. If signature is missing, plan may follow up and document, as described in Section 50.

| | Data Element | Required on enrollment mechanism? | Response required on enrollment request? |
|---|---|---|---|
| 16 | Date of signature | Yes | No[12] |
| 17 | Authorized Representative contact information (if not signed by beneficiary) | Yes | Yes |
| 18 | Information provided under "please read and sign below"<br><br>All elements provided in model language must be included on enrollment request mechanisms.<br><br>Option – can be provided as narrative or listed as statements of understanding | Yes | Yes |
| 19 | Release of Information<br><br>All elements provided in model language must be included on enrollment request mechanisms. | Yes | Yes |
| 20 | Beneficiary Gender Identity | Yes | No |
| 21 | Beneficiary Sexual Orientation | Yes | No |
| 22 | Beneficiary Ethnicity | Yes | No |
| 23 | Beneficiary Race | Yes | No |
| 24 | Option to request materials in language other than English (language preference) or in accessible formats | Yes | No |
| 25 | Notification of receiving plan materials electronically and ability to opt out | No | No |
| 26 | Question for individuals to indicate if they helped applicant with completing the form | Yes | Yes |
| 27 | Agent/Broker National Producer Number (NPN) | Yes | Yes[13] |

[12] As explained in § 50, the beneficiary and/or legal representative should provide the date they completed the enrollment form; however, if they inadvertently fail to include the date on the enrollment request, then the date of receipt that the PDP assigns to the enrollment request may serve as the signature date of the form. Therefore, the signature date is not a necessary element.

[13] Required for agents and brokers assisting the applicant with completing the enrollment form.

## Appendix 3: Setting the Application Date on CMS Enrollment Transactions

The application date submitted on enrollment transactions plays a key role in CMS system edits that ensure the beneficiary's choice of plan is honored. The application date is always a date prior to the effective date of enrollment.

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

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

## Appendix 4: Examples of Good Cause Determinations

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

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

**Favorable determination examples:**

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

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

**Example C:** Ms. Kim was disenrolled on August 31, 2024 following the plan's two month grace period. She states that she was displaced from her apartment due to a building fire in early June, was unable to access her belongings and as a result, was unable to make timely payment. The plan issues a favorable determination because Ms. Kim's home was significantly damaged by an unexpected and uncontrollable event during the plan's grace period. The plan's favorable determination is appropriate because: 1) The creditable

statement was provided about that the member's home was severely damaged due to an unexpected event; 2) The event (fire) was unexpected and out of the person's control; and 3) It is reasonable that the damage to Ms. Kim's home impaired her ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

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

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

**Example F:** Mrs. Duke was disenrolled on August 31, 2024 following the plan's two-month grace period. She states that her husband had been handling her bills and making payments timely. However, he passed away in July 2024, leaving her with no caregiver or family member to take over the responsibility. The plan issues a favorable good cause determination because of the recent death of Mrs. Duke's husband, which was unexpected and out of her control. The plan also offers Mrs. Duke the option to set up electronic payments and premium withholding to help ensure that she remains current in paying her premiums. The plan's favorable determination is appropriate because: 1) The credible statement was provided about the recent death of a spouse; 2) The event (death of spouse) was unexpected and out of the person's control; and 3) It is reasonable to conclude that the unexpected death impacted Mrs. Duke's ability to pay or make arrangements to pay the owed premiums within the plan's grace period.

**Example G:** Mr. Santiago lives in Lucas County, Iowa, and was disenrolled on July 31,

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

**Unfavorable determination examples:**

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

**Example B:** Mr. Jones was disenrolled on May 31, 2024 following the plan's two month grace period. He states that he was unable to pay his plan premiums because he has End-Stage Renal Disease (ESRD) and goes to a facility for dialysis three times a week. Mr. Jones states that he sometimes has difficulty keeping track of his monthly premium billing statements because of his frequent trips to the dialysis facility. The plan issues an unfavorable good cause determination because Mr. Jones has a known health issue and his need for routine dialysis is not unexpected in any way. While he has a chronic illness, he was receiving regular care to treat his condition, and it is reasonable to expect him, or someone acting on his behalf, to resolve the delinquency at some point during the plan's grace period. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which a chronic illness had newly developed serious complications which inhibited the ability to pay premiums timely; 2) The situation (chronic condition with no complications) did not render the individual without control over timely payment of his premiums; and 3) It is reasonable to expect that Mr. Jones could have paid or made arrangements to pay the owed amounts within the plan's grace period. Mr. Jones may

not be reinstated for good cause.

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

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

**Example E:** Ms. Adams was disenrolled on April 30, 2024 following the plan's three month grace period. She states that the basement in her home and her electricity were affected by recent flooding and that this prevented her from sending her monthly plan premium payments. Local road closures and power outages lasted for up to a week for some residents. The plan issues an unfavorable good cause determination because the local storms and subsequent flooding did not severely damage Ms. Adams home or prevent her from making the premium payments; further, there was neither a state nor federal disaster declaration. The plan's unfavorable determination is appropriate because: 1) The credible statement provided was not one in which the home was severely damaged nor was there a federal or state declaration of emergency; and 2) While road closures and power outages impacted some area residents, it isn't clear that Ms. Adams was directly impacted by these events or was impeded from being able to make timely payment; and 3) It is reasonable to

expect that Ms. Adams could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Adams may not be reinstated for good cause.

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

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

**Example H:** Ms. Ulman was disenrolled on June 30, 2024 following the plan's two-month grace period. She states that she needs to refill her medications and that she paid her owed amounts to the plan on July 20, 2024, following her disenrollment effective date. The plan issues an unfavorable good cause determination because Ms. Ulman's need for medications did not inhibit her ability to pay her premiums timely. The plan's unfavorable determination is appropriate because: 1) The situation (medication needs) was not unexpected or out of the person's control, nor did it impede her ability to pay timely; and 2) It is reasonable to expect that Ms. Ulman could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Ulman may not be reinstated for good cause.

**Example I:** Ms. Taylor was disenrolled on March 31, 2024 following a plan's three-month grace period. She states that when she enrolled in the plan during the fall open enrollment period, she selected premium withhold as the method of premium payment. She says that she received a premium bill from the new plan for January and, in addition, received a delinquency notice in early January warning of disenrollment at the end of March if she did not pay the premium for January. She stated that she ignored the bill and the delinquency notice, assuming that her plan premiums were being withheld from her Social Security benefit check starting with the January premium. The plan issues an unfavorable good cause determination because the plan explained in its letter to Ms. Taylor following submission of

the enrollment transaction and receipt of the TRR that her first month's plan premium was not withheld, that she was responsible for paying her premiums until premium withholding started and that she could be involuntarily disenrolled. The plan concluded that Ms. Taylor had been appropriately advised of her obligation to pay the bill for the January premium and that this was reiterated by means of the subsequent premium bills and the delinquency letter the plan sent to her in January. The plan's unfavorable determination is appropriate because: 1) The situation (misunderstanding of ramifications of nonpayment of premiums) was not unexpected in any way; 2) The situation did not impede her ability to pay timely; and 3) It is reasonable to expect that Ms. Taylor could have paid or made arrangements to pay the owed amounts within the plan's grace period. Ms. Taylor may not be reinstated for good cause.

# Exhibits

## PDP Model Enrollment Forms & Notices

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

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

# Exhibit 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN (PART D)

## Who can use this form?

People with Medicare who want to join a Medicare Prescription Drug Plan

**To join a plan, you must:**

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

**Important:** To join a Medicare Prescription Drug Plan, you must also have either, or both:

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

## When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

## What do I need to complete this form?

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

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

## Reminders:

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

## What happens next?

Send your completed and signed form to:
<Plan Name>
<Plan address>
<Plan address>
<Plan address>

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

## How do I get help with this form?

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

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

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

## Individuals experiencing homelessness

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

| Section 1 – All fields on this page are required (unless marked optional) | | | |
|---|---|---|---|
| **Select the plan you want to join:**<br>☐ Product ABC – $XX per month ☐ Product XYZ – $XX per month | | | |
| FIRST name: LAST name: [Optional: Middle Initial]: | | | |
| Birth date: (MM/DD/YYYY)<br>(__ __/__ __/__ __ __ __) | Sex:<br>☐ Male ☐ Female | Phone number:<br>(  ) | |
| Permanent Residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.): | | | |
| City: | [Optional: County]: | State: | ZIP Code: |
| Mailing address, if different from your permanent address (PO Box allowed):<br>Street address: City: State: ZIP Code: | | | |
| **Your Medicare information:** | | | |
| **Medicare Number:** _ _ _ _ - _ _ _ - _ _ _ _ | | | |
| **Answer these important questions:** | | | |
| [*PDPs insert:*<br>Will you have other prescription drug coverage (like VA, TRICARE) in addition to < Plan>? ☐ Yes ☐ No<br>Name of other coverage: Member number for this coverage: Group number for this coverage<br>_____ _____ _____] | | | |
| *[Special Needs Plans] insert question(s) regarding the required special needs criteria]* | | | |
| **IMPORTANT: Read and sign below:** | | | |
| • [*Part D plans insert:* I must keep Hospital (Part A) or Medical (Part B) to stay in <Plan Name>.]<br>• By joining this Medicare Prescription Drug Plan, I acknowledge that <Plan Name> will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.<br>• I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.<br>• [*MA-PD plans insert:* I understand that when my <Plan Name> coverage begins, I must get all of my medical and prescription drug benefits from <Plan Name>. Benefits and services provided by <Plan Name> and contained in my <Plan Name> "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor <Plan Name> will pay for benefits or services that are not covered.]<br>• The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.<br>• I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:<br>1) This person is authorized under State law to complete this enrollment, and<br>2) Documentation of this authority is available upon request by Medicare. | | | |
| **Signature:** | **Today's date:** | | |
| If you're the authorized representative, sign above and fill out these fields: | | | |
| Name: | Address: | | |
| Phone number: | Relationship to enrollee: | | |

## Section 2 – All fields in this section are optional

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

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

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer.**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Black or African American

Asian:
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander:
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ White
☐ **I choose not to answer.**

What is your gender? Select one.

☐ Woman
☐ Man
☐ Non-binary
☐ I use a different term: _____
☐ **I choose not to answer**

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

☐ Lesbian or gay
☐ Straight, that is, not gay or lesbian
☐ Bisexual
☐ I use a different term: _____
☐ I don't know
☐ **I choose not to answer**

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

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

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

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

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

Do you work? ☐ Yes ☐ No

Does your spouse work? ☐ Yes ☐ No

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

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

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

E-mail address:

## Paying your plan premiums

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

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

## For individuals helping enrollee with completing this form only

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

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

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

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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

**Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual enrollment period from October 15 through December 7 of each year**. Additionally, there are exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

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

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

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

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

## Exhibit 1b: Model Short Enrollment Form ("Election" may also be used)

This form may be used in place of the model individual enrollment form when a member of a PDP sponsor is enrolling into another plan benefit package offered by the same parent organization.

| | | |
|---|---|---|
| **Name of Plan You are Enrolling In: _____** | | |
| **Name**: | **Medicare Number: _____**<br>[Note: may use "member number" instead of "Medicare number"] | |
| Home Phone Number: | | |
| Permanent Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.): | | |
| City: | State: | ZIP Code: |

**Mailing Address** (only if different from your Permanent Street Address):

Street Address: City: State: ZIP Code:

**Please fill out the following:**

I am currently a member of the _____ plan in <PDP name> with a monthly premium of $_____ .

I would like to change to the _____ plan in <PDP name>. I understand that this plan has different prescription benefits and a monthly premium of $____.

### The fields in this section are optional

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

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

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian and Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer.**

What is your gender? Select one.

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ I use a different term: _____
- ☐ **I choose not to answer**

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

☐ Lesbian or gay
☐ Straight, that is, not gay or lesbian
☐ Bisexual
☐ I use a different term: _____
☐ I don't know
☐ **I choose not to answer**

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

____ <include list of available languages>

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

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

## Your Plan Premium

**You can pay your monthly plan premium (including any late enrollment penalty you may owe) by mail <***insert optional methods*: **"Electronic Funds Transfer (EFT)", "credit card"> each month <***insert optional intervals, if applicable, for example* **"or quarterly">. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefits check each month.**

**If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DON'T pay <plan name> the Part D- IRMAA extra amount.**

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

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

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

**Please select a premium payment option:**

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

☐ Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.
I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the

first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

## Please Read and Sign Below:

<PDP name> is a Medicare prescription drug plan and has a contract with the Federal government.

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

**Release of Information:** By joining this Prescription Drug Plan, I acknowledge that the Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <plan name> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date [name of plan] coverage begins, I must get all of my prescription drug services from <plan name>. Prescription drugs authorized by <plan name> and contained in my <plan name> Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR <Plan Name> WILL PAY FOR THE SERVICES.**

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

| **Signature:** | **Today's Date:** |
|---|---|
| | |

If you are the authorized representative, you must sign above and provide the following information:
**Name:** _____
**Address:** _____
**Phone Number**: (__) ____- _____
**Relationship to Enrollee** _____

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

## Exhibit 1c: Model Plan Selection Form for Switch from Plan to Plan within Parent Organization

Dear <plan name> Member:

*<Introduction - In the introduction of cover letter, PDP sponsor may include language regarding plan choices, description of plans, differences, etc.>.*

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

You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

If you select another plan and we receive your completed selection form by <date>, your new benefit plan will begin in <month/year>. Your monthly plan premium will be <premium amount> and you may continue to use any <current plan name> pharmacies.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included <year> <Summary of Benefits or benefit overview> for the available options.

If you have any questions, please call <plan name> at <phone number - if plan is planning to have informational meetings - include information about time/place of meetings >. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>.

Thank you.

## Plan Selection Form

Date:
Member Name:
Member Number:

I want to transfer from my current Part D plan to the Part D plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month.

Please check the appropriate box below <list all available plans>:

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: deductible, copays, etc.>

____ <Name of Plan>
<monthly premium amount>
<brief description of benefit - include items such as: deductible, copays, etc.>

### Your Plan Premium

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

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

**If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. DON'T pay <plan name> the Part D-IRMAA extra amount.**

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

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

**Please select a premium payment option:**

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

Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

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

| **The fields in this section are optional** | |
|---|---|
| **Answering these questions is your choice. You can't be denied coverage because you don't fill them out.** | |
| Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.<br>☐ No, not of Hispanic, Latino/a, or Spanish origin<br>☐ Yes, Puerto Rican<br>☐ Yes, another Hispanic, Latino/a, or Spanish origin<br>☐ **I choose not to answer.** | ☐ Yes, Mexican, Mexican American, Chicano/a<br>☐ Yes, Cuban |
| What's your race? Select all that apply.<br>☐ American Indian or Alaska Native<br>Asian:<br>☐ Asian Indian<br>☐ Chinese<br>☐ Filipino<br>☐ Japanese<br>☐ Korean<br>☐ Vietnamese<br>☐ Other Asian | ☐ Black or African American<br>Native Hawaiian and Pacific Islander:<br>☐ Guamanian or Chamorro<br>☐ Native Hawaiian<br>☐ Samoan<br>☐ Other Pacific Islander<br>☐ White<br>☐ **I choose not to answer.** |
| What is your gender? Select one. | |
| ☐ Woman | ☐ I use a different term: |
| ☐ Man | ☐ **I choose not to answer** |
| ☐ Non-binary | |

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

| Which of the following best represents how you think of yourself? Select one. | |
|---|---|
| ☐ Lesbian or gay | ☐ I use a different term: _____ |
| ☐ Straight, that is, not gay or lesbian | ☐ I don't know |
| ☐ Bisexual | ☐ **I choose not to answer** |
| | |

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

_____ <include list of available languages>

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

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

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

| **Signature:** | **Today's Date:** |
|---|---|
| | |

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

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

**Please mail this form to:**
**<Insert mailing address>**

## For individuals helping enrollee with completing this form only

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

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

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

## Exhibit 2: PDP Model Notice to Acknowledge Receipt of Completed Enrollment

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

<Date>
Dear <Name of Member>:

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

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

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

[*PDP plans without a premium – do not use the following Q&A*:
**Will <PDP name> bill me directly for my premiums or will my premiums be deducted from my Social Security/Railroad Retirement Board check?**
Your enrollment form included the options for paying your plan premium. If you chose to have your <PDP name> premium withheld from your Social Security or Railroad Retirement Board benefit check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away or doesn't start at all. If you didn't choose this option, we will bill you for your monthly premiums. Generally, you must stay with the premium payment option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

**What is Extra Help?**

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

**What if I have other health coverage?**
If you have other health coverage, such as from an employer or union, joining <PDP Name> may change how your current coverage works. Read the communications your other health coverage sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help. If you have other prescription drug coverage, such as through an employer plan, you shouldn't cancel your other coverage yet. Keep your other coverage until you receive the confirmation letter from us.

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

**When can I make changes to my Medicare prescription drug coverage?**
You can change prescription drug plans only at certain times during the year.
**From October 15 - December 7**, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain circumstances, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

**Where can I fill my prescriptions?**
Please remember that you should use <PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

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

Thank you.

## Exhibit 2a: Model Notice to Acknowledge Receipt of Completed Enrollment Request for another Plan in the Same Parent Organization

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

<Date>
Dear < Member>:

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

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

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

**When can I make changes to my prescription drug coverage?**
You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or qualify for extra help (or lose) Extra Help paying for your prescription drug costs.

If you have questions about how or when to disenroll from <new PDP name>, please call our customer service department at the phone number at the end of this letter.

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

Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

[*PDP plans without a premium – do not use the following Q&A*:
**Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security/Railroad Retirement Board check?**
Your enrollment form included the options for paying your plan premium. If you chose to have your monthly premium for this plan withheld from your Social Security or Railroad Retirement Board payment, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away or doesn't start at all. If you did not choose this option, we will bill you for your monthly premium. Generally, you must stay with the premium payment option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence*: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

**Where can I fill my prescriptions?**
Please remember that you should use <new PDP name> network pharmacies to fill your prescriptions beginning on <effective date>. If you use an out-of-network pharmacy, except in an emergency, <new PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling customer service at the number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

**What if I have more questions?**
If you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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

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

<Date>
Dear <Name of Member>:

Thank you for enrolling in <PDP name>. <PDP name> is a Prescription Drug Plan that is approved by Medicare. Medicare has approved your enrollment in <PDP name> beginning <effective date>.

**How will my coverage work?**
As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service department. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.] [*Optional language***:** This letter is proof of insurance that you should show to your pharmacy until you get your Member ID card from us**.**]

**How much is my premium?**
[*Insert the following if no low-income subsidy:* The premium for your plan is: [insert premium]. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please call <PDP name> at the number provided at the end of this letter.

[*Insert if low-income subsidy applicable:*
**What are my costs since I qualify for Extra Help?**
Because you qualify for Extra Help with your prescription drug costs, you will pay no more than:

- <plan premium less premium assistance for which individual is eligible> per month for your <PDP name> premium,
- <insert appropriate LIS copay amount> when you fill a prescription.

If you believe this is incorrect and you have proof that that the Extra Help amounts should be different, please call <PDP name> at the number provided at the end of this letter.]

**Will I pay a late enrollment penalty as part of my premium?**
[*Insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call *<plan name>* at the number provided at the end of this letter. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE

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

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

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

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

[*Part D plans without a premium – do not use the following paragraph*:
**Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security check?**
Your enrollment form included the options for paying your plan premium. If you chose to have your <PDP name> premium withheld from your Social Security or Railroad Retirement Board benefit check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away or doesn't start at all. If you didn't choose this option, we will bill you for your monthly plan premiums. Generally, you must stay with the premium payment option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence:* "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

**When can I make changes to my coverage?**
You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

[*Insert if low-income subsidy NOT applicable:*
**What is Extra Help?**
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could help pay for your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these

savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.]

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

**What if I have more questions?**
If you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

## Exhibit 3: Model Notice to Request Information

<Date>

Dear <Name of Member>:

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

_____ Proof that you have Medicare. Please provide us your Medicare Number. Your Medicare Number is printed on your Medicare card. You can also get your number by:

- Logging into your ssa.gov/myaccount or MyMedicare.gov accounts;
- Calling Social Security at 1-800-772-1213 (TTY: 1-800-325-0778); or
- Calling Medicare at 1-800-Medicare (1-800-633-4227; TTY: 1-800-486-2048).

_____ Other: _____

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

You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help with your prescription coverage (see below).

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

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

Thank you.

## Exhibit 4: PDP Model Notice to Confirm Enrollment

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

<Date>

Dear <Name of Member>:

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

**How will my coverage work?**
As of <effective date>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service department at the number at the end of this letter. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

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

[*Insert the following if no low-income subsidy:*
**How much is my premium?**
The monthly premium for your plan is <premium amount>.

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

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

[*Insert if low-income subsidy applicable:*
**What are my costs since I qualify for extra help?**
Because you qualify for extra help with your prescription drug costs, you will pay no more than:

- <plan premium less premium assistance for which individual is eligible> per month

for your <PDP name> premium,

- <insert appropriate LIS copay amount > when you fill a prescription covered by <PDP name>.

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

**Will I pay a late enrollment penalty as part of my premium?**
[*Insert the following for new members with an existing LEP:* Your premium continues to reflect a late enrollment penalty amount that was based on information sent by your previous plan. Your plan should have told you about this penalty. If you have questions about the late enrollment penalty, call <*plan name*> at the phone number provided at the end of this letter. You can also get information by visiting www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. If we determine that your penalty needs to be adjusted, we will notify you of your new monthly premium.]

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

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

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

[*Part D plans without a premium – do not use the following paragraph*:
**Will <plan name> bill me for my premiums or will my premiums be deducted from my Social Security/Railroad Retirement Board check?**
Your enrollment form included the options for paying your plan premium. If you chose to have your <PDP name> premium withheld from your Social Security or Railroad Retirement Board benefit check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away or doesn't start at all. If you didn't choose this option, we will bill you for your monthly premiums. Generally, you must stay with the premium payment option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please contact us at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. [*PDPs that disenroll for nonpayment of premium include the following sentence*: "Members who fail to pay the monthly premium may be disenrolled from <PDP name>".]

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

**What if I have more questions?**
If you have any questions, please contact <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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

<Date>

Dear < Member>:

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

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

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

If you have already discussed this decision with your employer or union contact and have decided that you would like to be a member of <PDP name>, **please call <PDP name> at the phone number provided below.** Your enrollment won't be complete until you call and confirm this information.

We must hear from you to enroll you in our plan. If we don't hear from you within 30 days from the date of this notice, we won't process your enrollment.

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

Thank you.

## Exhibit 6: PDP Model Notice for Denial of Enrollment

<Date>

Dear <Name of Beneficiary>:

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

1. _____ You have neither Medicare Part A nor Part B.
2. _____ You are unlawfully present in the United States.
3. _____ You are incarcerated and currently reside outside our service area.
4. _____ Your permanent residence is outside of our service area.
5. _____ You attempted to enroll outside of an enrollment period or don't qualify for an enrollment period at this time.
6. _____ We didn't get the information we requested from you within the timeframe listed in our request.
7. _____ The request was made by someone other than the beneficiary and that individual isn't the beneficiary's authorized representative.

[8. _____ You have drug coverage such as from an employer or union and you told us you don't want to join <PDP name>.]

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

[Insert if item 2 or 3 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S. or if you're incarcerated]

If item 5 is selected: You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

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

Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.ssa.gov/medicare/part-d-extra-help.

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

Thank you.

## Exhibit 7: PDP Model Notice for CMS Rejection of Enrollment

<Date>

Dear <Name of Beneficiary>:

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

1. _____ You have neither Medicare Part A nor Part B.
2. _____ You are unlawfully present in the United States.
3. _____ You are incarcerated and currently reside out of our service area.
4. _____ You requested to enroll in a different Plan for the same effective date, which canceled your enrollment with <PDP name>.
5. _____ You attempted to enroll outside of an enrollment period or don't qualify for an enrollment period at this time.

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

[Insert if item 2 or 3 is selected: Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S. or if you're incarcerated]

If item 5 is selected: You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

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

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

Thank you.

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

## Exhibit 8: PDP Model Notice to Send Out Disenrollment Form

<Date>

Dear <Member>:

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

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

Until your disenrollment date, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy except in an emergency, <PDP name> may not pay for your prescriptions. After your disenrollment date, <PDP name> won't cover your prescription drugs.

**When can I make changes to my Medicare coverage?**
You can change prescription drug plans only at certain times during the year. **From October 15 – December 7**, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of <PDP name>'s service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs (see below).

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

**When should I submit a disenrollment request?**
You **should not** fill out the attached form if you are planning to enroll, or have enrolled, in another Medicare Prescription Drug Plan or Medicare Advantage Prescription Drug Plan. Enrolling in a prescription drug plan or a Medicare Advantage-Prescription Drug Plan will automatically disenroll you from <PDP name>.

You **should** fill out the attached form only if you no longer want Medicare prescription drug coverage and want to disenroll from this coverage completely.

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

Instead of sending a disenrollment request to <plan name> you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

By disenrolling from <PDP name>, you are disenrolling from your Medicare prescription drug coverage. You may have to pay a late enrollment penalty in addition to your premium for Medicare Prescription Drug coverage if you join a Medicare Drug Plan in the future. For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

Attachment

## Exhibit 9: PDP Model Disenrollment Form

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

Instead of sending a disenrollment request to <plan name> you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

| Last Name: First Name: Middle Initial: | | |
|---|---|---|
| Member ID: | | |
| Birth Date: | Sex: ☐ M ☐ F | Home Phone Number: ( ) |

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

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

Signature* _____ Date: _____

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

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

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

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

## Exhibit 9a: Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

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

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

- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.

- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.

- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.

- ☐ I am joining a PACE program on (insert date) _____.

- ☐ I am joining employer or union coverage on (insert date) _____.

- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.

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

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

<Date>

Dear < Member>:

We received your request to disenroll from <PDP name>. You will be disenrolled starting <effective date>. Therefore, beginning <effective date>, <PDP name> won't cover your prescription drugs.

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

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

**What if my premium was being deducted from my Social Security benefit check?**
If your Medicare Part D premium is being deducted from your Social Security/Railroad Retirement Board benefit, please allow up to 3 months for us to process a refund. If you have not received a refund from Social Security/the Railroad Retirement Board within 3 months of this letter, you should contact 1-800-MEDICARE.

**When can I make changes to my Medicare coverage?**
You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

**Where can I get more information?**

For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

## Exhibit 10a: PDP Notice to Confirm Voluntary Disenrollment Identified Through TRR

<Date>

Dear <Name of Member>:

This is to confirm your disenrollment from <PDP name>. Beginning <effective date>, <PDP name> won't cover your prescription drugs.

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

**What if my premium was being deducted from my Social Security/Railroad Retirement Board benefit check?**
If your Medicare Part D premium is being deducted from your Social Security/Railroad Retirement Board benefit, please allow up to 3 months for us to process a refund. If you have not received a refund from Social Security/the Railroad Retirement Board within 3 months of this letter, you should contact 1-800-MEDICARE.

**When can I make changes to my Medicare coverage?**
You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

**Where can I get more information?**
For information about the Medicare plans available in your area, call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

If you think you didn't disenroll from <PDP name> and you want to stay a member of our plan, please call us right away at <toll-free number> <days and hours of operation> so we can make

sure you stay a member of <PDP name>. Medicare gives you only 30 days from the date of this letter to contact us. TTY users should call <toll-free TTY number>.

Thank you.

## Exhibit 10b: PDP Notice to Confirm Disenrollment Identified Through Transaction Reply Report – Reassigned LIS

<Date>

Dear <Name of Member>:

This is to confirm your disenrollment from <PDP name>. Beginning <effective date>, <PDP name> won't cover your prescription drugs. You got a blue letter from Medicare in October explaining that Medicare will switch you to another Medicare drug plan starting January 1, <following calendar year>. This is because it will cost you more if you stay in <PDP name>.

If you haven't already, you should soon get a letter from your new plan confirming your enrollment that will take effect on January 1, <following calendar year>.

You can call this new plan with questions about their coverage, formulary, and pharmacy list.

If you have questions about why Medicare changed your plan or other Medicare plans available in your area, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048).

If you have questions about this disenrollment from <PDP name> or you want to remain a member of our plan, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

## Exhibit 10c: Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan

**IMPORTANT INFORMATION ABOUT YOUR UPCOMING DISENROLLMENT FROM YOUR MEDICARE PRESCRIPTION DRUG PLAN**

<Date>

Dear <Name of Member>:

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

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

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

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

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

Thank you.

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

## Exhibit 11: PDP Notice for Part D Plan Denial of Disenrollment

<Date>

Dear <Member>:

We recently got your request to disenroll from <PDP name>. We cannot accept your request for disenrollment for the reason checked below:

1. _____ You attempted to make a change to <PDP name> outside of an enrollment period or you don't qualify for an enrollment period at this time. Medicare limits when and how often you can make changes to your coverage.

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

3. _____ We didn't get the information we requested from you within the timeframe listed in our request.

You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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

Dear <Name of Member>:

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

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

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

_____ During certain times of the year, Medicare doesn't let you disenroll unless you meet certain special exceptions. Please call us at the number below to help us determine if you're able to disenroll at this time.

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

_____ Other: _____

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

<PDP name>
<mailing address>
<toll free number and days/hours of operation)
<TTY toll-free number>

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

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

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

Thank you.

## Exhibit 12: PDP Model Notice for CMS Rejection of Disenrollment

<Date>

Dear < Member>:

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

You can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

If you believe this information is wrong, or if you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

## Exhibit 13: PDP Model Notice of Disenrollment Due to Death

<Date>

To the Estate of < Member>:

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

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

If the Medicare Part D premium was being deducted from <Name of Member>'s Social Security benefit, please allow up to 3 months for us to process a refund. If the estate has not received a refund from Social Security within 3 months of this letter, a representative of the estate should contact 1-800-MEDICARE.

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

Thank you.

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

<Date>

To the Estate of < Member>:

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

We are sending this letter because Medicare had enrolled <Name of Member> in <PDP name>, a plan that provides Medicare prescription drug coverage. Because of this report of death, <Name of Member>'s coverage in <PDP name> ends as of <disenrollment effective date>. If plan premiums were paid for any month after <disenrollment effective date>, we will issue a refund to the Estate within 30 days of this letter

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

Thank you.

## Exhibit 14: PDP Model Notice of Disenrollment Due to Loss of Part D Eligibility

<Date>

Dear < Member>:

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

If you haven't already done so, please contact your local Social Security office to have their records corrected. Or, you can call Social Security at 1-800-772-1213 from 7:00 AM to 7:00 PM, Monday to Friday. TTY users should call 1-800-325-0778.

If this information is wrong, and you want to stay a member of our plan, please contact us. If you have any questions, please call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

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

<Date>

Dear < Member>:

Medicare's records incorrectly show you as deceased.

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

In the meantime, you should keep using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

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

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

<Date>

Dear < Member>:

On <date of request>, you told us that your enrollment in Medicare <insert Part A and/or Part B as appropriate> was ended in error and that you want to stay a member of <PDP name>.

[*Sponsors that are able to verify current Medicare entitlement may omit the following*:
To do this, please complete the following three steps no later than <insert date: 60 days from date of disenrollment notice>:

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

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

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

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

In the meantime, you should keep using <PDP name> network pharmacies to fill your prescriptions to get <PDP name> prescription coverage. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

[*Sponsors that are able to verify current Medicare entitlement may omit the following*:
If we learn that you don't have Medicare <insert Part A and/or Part B as appropriate>, or if we don't get proof that you have Medicare by <insert date: 60 days from date of disenrollment notice>, you will have to pay for any prescription drugs you filled after <disenrollment date>.]

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

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

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

<Date>

Dear < Member>:

Thank you for letting us know you want to remain a member of <PDP name> after we mistakenly [*select one based on circumstance:* disenrolled you from/cancelled your enrollment in] our plan. [*Insert brief summary of the plan error that caused the disenrollment.]* We apologize for the inconvenience. We have changed our records to show that you are still a member of <PDP name>. You should keep using your <PDP name> pharmacies to fill your prescriptions.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

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

Thank you.

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

## Exhibit 18: PDP Model Notice to Close Out Request for Reinstatement

<Date>

Dear < Beneficiary>:

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

You were no longer a member of our plan as of <effective date>. If <PDP name> paid any costs for prescriptions you filled after <effective date>, we will bill you for the amount we paid.

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

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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

<Date>

Dear < Member>:

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

**This letter applies only to your <PDP name> benefits. Your other Medicare benefits won't be affected if you are disenrolled from <PDP name>.**
If you don't want to be a member of <PDP name> and don't want any other Medicare drug plan, you may be able to disenroll from <PDP name>. However, you can change prescription drug plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

Also, if you don't have or get other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty for Medicare prescription drug coverage in the future.

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

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

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

If you paid the premium recently and you think we have made a mistake, or if you have any questions, please call < PDP name > at <toll-free number>, <days and hours of operation>. TTY users should call <toll-free TTY number>.
Thank you.

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

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

<Date>

Dear < Member>:

On <date of notification letter>, we mailed you a letter stating that your plan premium was overdue. The letter said that if you didn't pay your premium, we would disenroll you from < PDP name >. Since we didn't get that payment, we have asked Medicare to disenroll you. Your disenrollment from < PDP name > will be effective <effective date>. After <effective date>, < PDP name > won't cover your prescription drugs.

**This letter only applies to your <PDP name> benefits. Your other Medicare benefits aren't affected by your disenrollment from < PDP name >.** [*Cost plans where individual is losing optional supplemental Part D benefit only, replace prior sentence with:* This letter only applies to your prescription drug coverage. You will still have health coverage through <*cost plan name*>.]

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

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

**When can I get Part D coverage?**
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

**Can I get help paying my premiums and other out-of-pocket costs?**
People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for your drug costs including monthly prescription

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

**For more information:**
If you have any questions or if you have recently sent us a payment, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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

Dear < Member>:

Medicare has confirmed your disenrollment from < PDP name > because you didn't pay your plan premium. Your disenrollment begins <effective date>. As of <effective date>, <PDP name> won't cover your prescription drugs.

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

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

**When can I get Part D coverage?**
Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

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

**For more information:**
If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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

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

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

<Date>

Dear < Member>:

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

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

This decision was made by Medicare, not by <Part D plan sponsor name>.

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

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

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

**When can I get Part D coverage?**
Medicare limits when you can make changes to your coverage. From October 15 through December 7 of each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations,

such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

Thank you.

## Exhibit 21b: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Part D-IRMAA – Notification of Plan Premium Amount Due for Reinstatement

Dear <Name of Member>:

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

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

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

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

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

**When can I get Part D coverage?**
Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

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

Thank you.

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

## Exhibit 21c: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums – Notification of Plan Premium Amount Due for Reinstatement

Dear <Name of Member>:

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

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

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

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

**When can I get Part D coverage?**
Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

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

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

**For more information:**

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

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

Thank you.

## Exhibit 21d: Model Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums

Dear <Name of Member>:

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

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

**When can I get Part D coverage?**
Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

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

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

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

Thank you.

## Exhibit 21e: Model Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment

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

Dear <Member>:

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

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

**Your Payment Wasn't Received on Time**

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

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

**When can I get Part D coverage?**
Medicare limits when you can make changes to your coverage. **From October 15 through December 7 each year**, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

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

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

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

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

Thank you.

## Exhibit 21f: Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement)

<Member # >

*RxID*
*RxGroup*
*RxBin*
*RxPCN*

Dear <Beneficiary Name>:

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

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

You should continue to fill your prescriptions at <PDP name> network pharmacies.

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

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

## Exhibit 22: Model Acknowledgement of Request to Cancel Enrollment Request

<Date>

Dear < Member>:

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

**IMPORTANT: If you were enrolled in another Medicare Prescription Drug Plan or a Medicare Health Plan (such as a Medicare HMO or PPO) before enrolling with < PDP name >, you should be automatically enrolled back into that plan.**

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

Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

Please remember that if you don't have or get prescription drug coverage that is at least as good as Medicare's (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

## Exhibit 22a: Model Confirmation of Reinstatement

Dear <member name>:

Please be sure to keep this letter for your records.

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

You should keep using your <plan name> pharmacy for your health care.

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

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

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

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

## Exhibit 23: Model Acknowledgement of Request to Cancel Disenrollment Letter

<Date>

Dear < Member>:

As you requested, we have cancelled your disenrollment with < PDP name >. Thank you for your continued membership in our plan.

You should continue to fill your prescriptions at < PDP name > network pharmacies. If you use an out-of-network pharmacy, except in an emergency, < PDP name > may not pay for your prescriptions. You can find network pharmacies in your area by looking in your pharmacy directory or by calling our customer service number below. [*Optional language:* You can also visit the <plan/organization name> website at <plan website address>.]

**IMPORTANT:** If you submitted an enrollment request to another Prescription Drug Plan or a Medicare Advantage Plan, you may appear on their records as being enrolled in their plan. Since you have told us you want to stay enrolled in < PDP name >, you will need to contact the other plan to ask them to cancel your enrollment before your enrollment takes effect. They may ask you to write them a letter for their records.

Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

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

If you have any questions, please call <PDP name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

## Exhibit 24: PDP Model Notice to Confirm Auto-Enrollment

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

Dear <insert member name>

You are getting this letter because Medicare is enrolling you in our <PDP name>, and your coverage begins <effective date>. Medicare is also mailing you a yellow letter about your enrollment. Please keep both letters for your records.

[*Optional*: You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

**What are my costs in this plan?**
Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- $0 per month for your < PDP name > premium,
- $0 for your yearly prescription drug plan deductible,
- <insert applicable copay levels> when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <PDP name> at the number below.

**What if Medicaid used to pay for my prescription drugs?**
Remember, if Medicaid used to pay for your prescription drugs, Medicaid won't continue to cover the drugs it used to. Some state Medicaid programs may cover the few prescriptions that won't be covered under Medicare prescription drug coverage. But even if your state Medicaid program covers a few prescriptions, this coverage alone won't be as good as Medicare's (also referred to as "creditable coverage"). To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>.

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

**What if I have other prescription drug coverage?**
If you now have or are eligible for other types of prescription drug coverage, you may not need to join a Medicare drug plan. **You or your dependents could lose your other health or drug coverage completely and not get it back if you join a Medicare drug plan.** Read all the materials you get from your insurer or plan provider to learn how joining a Medicare drug plan

may affect you or your family's current coverage. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, the Department of Veterans Affairs, or a Medigap (Medicare Supplement Insurance) policy. Please call your insurer or benefits administrator if you have any questions.

**What if I want to join another plan or I don't want Medicare prescription drug coverage?** You are not required to be in our Medicare prescription drug plan. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join.

If you don't want Medicare prescription drug coverage at all, call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week). TTY users should call 1-877-486-2048.

Thank you.

## Exhibit 25: PDP Model Notice to Confirm Facilitated Enrollment

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

Dear < member >

You are getting this letter because Medicare is enrolling you in our <PDP name> and your coverage begins <effective date>. Medicare is also mailing you a green letter about your enrollment. If you want coverage to begin earlier, you must tell us by <last day of month that is two months earlier than effective date>.

[*Optional*: You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

**What are my costs in this plan?**
Because you qualify for extra help with your prescription drug costs, you will pay no more than the following:

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert applicable deductible> for your yearly prescription drug plan deductible,
- <insert copay amount or 15% coinsurance> when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please call <PDP name> at the number below.

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

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

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

**What if I want to join another plan, or I don't want Medicare prescription drug coverage?**
You are not required to be in our Medicare prescription drug plan. If you want to join a different Medicare prescription drug plan, simply call that plan to find out how to join.

If you don't want Medicare prescription drug coverage at all, call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <insert days/hours of operation and, if different, TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week). TTY users should call 1-877-486-2048.

Thank you.

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

<Date>

Dear <name of applicant>:

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

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

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

If you qualify for (or lose) Extra Help with your prescription drug costs you may have a special enrollment period to enroll in, or disenroll from, a Medicare health or prescription drug plan.

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

Thank you.

## Exhibit 26: PDP Acknowledgement of Request to Decline or Opt-Out of Part D Prior to Effective Date

<Date>

Dear < Member>:

As you requested, < PDP name > has processed your request to decline (opt-out of) Medicare prescription drug coverage. Your decision to decline Medicare prescription drug coverage doesn't affect your enrollment in Medicare Part A or Part B. **If you have drug coverage through Medicaid (Medical Assistance), that program will no longer pay for your prescription drugs.**

Remember, like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy.

*[Insert if individual qualifies for extra help:* Our records show that you are eligible for Extra Help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.*]*

If you change your mind and decide you would like to join, please contact < PDP name > at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or visit www.medicare.gov. TTY users should call 1-877-486-2048

Thank you.

## Exhibit 26a: PDP Acknowledgement of Request to Disenroll from PDP and Opt-Out of Part D After Effective Date

<Date>

Dear < Member>:

As you requested, < PDP name > has processed your request to disenroll from (opt-out of) Medicare prescription drug coverage. Your decision to disenroll from Medicare prescription drug coverage doesn't affect your enrollment in Medicare Part A or Part B. Your disenrollment from <PDP name> is effective <effective date>. After this date, < PDP name> will no longer pay for your prescription drugs. **If you previously had drug coverage through Medicaid (Medical Assistance), that program will no longer pay for your prescription drugs.**

Remember, like other insurance, Medicare prescription drug coverage will be there when you need it to help you with drug costs. Even if you don't take a lot of prescription drugs now, you still should consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy.

*[Insert if individual qualifies for extra help:* Our records show that you are eligible for Extra Help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.*]*

If you change your mind and decide you would like to remain in our plan, please contact < PDP name > at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>. You can also call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) or visit www.medicare.gov. TTY users should call 1-877-486-2048

Thank you.

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

## Exhibit 27: Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor Offers another PDP at or below the Low-Income Premium Subsidy Amount for that Region

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

<Date>

Dear < Member>:

You recently told us that you live in <state>. To make sure that you have Medicare prescription drug coverage where you live, we are enrolling you in <PDP name> that serves <insert states in the new plan's region>. Your new coverage will begin < effective date>.

If you disagree with the information in this letter or if you have any questions, please call <PDP name> at the phone number provided at the end of this letter.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us.]

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

- <plan premium less premium assistance for which individual is eligible> per month for your < PDP name > premium,
- <insert applicable deductible> for your yearly prescription drug plan deductible,
- <insert applicable copayments] when you fill a prescription covered by our plan.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact <PDP name>.

You aren't required to be in <PDP name>. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join. You can also call 1-800-MEDICARE (1-800-633-4227, which is open 24 hours a day, 7 days a week) or visit www.medicare.gov on the web to choose and join a plan in your area that meets your needs. TTY users should call 1-877-486-2048.

If you have any questions, please call our <Customer Service, Member Services> department at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

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

## Exhibit 28: Auto and Facilitated Enrollees Who Permanently Reside in another Region Where the PDP Sponsor DOES NOT offer another PDP at or below the Low-Income Premium Subsidy Amount for that Region

<Date>

Dear < Member>:

You recently told us that you live in a place where we don't provide a Medicare prescription drug plan with premiums fully covered by extra help. You must live in <insert states where current PDP is offered> to be enrolled in <PDP name>. We have asked Medicare to disenroll you from < PDP name > beginning <effective date>.

It is important for you to call 1-800-MEDICARE (1-800-633-4227, which is available 24 hours a day, 7 days a week) to choose and join a plan that serves your state or territory. TTY users should call 1-877-486-2048. If you want to learn about other Medicare prescription drug plans in your area that you can join, call 1-800-MEDICARE or visit www.medicare.gov.

If you disagree with the information in this letter or if you have any questions, please call customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

## Exhibit 29: Model Reassignment Confirmation

**<Member #>**
**<RxID>**
**<RxGroup>**
**<RxBIN>**
**<RxPCN**

Dear < member >

You are getting this letter because Medicare has enrolled you in <PDP name> for coverage beginning January 1, <following calendar year>. You should have already received a blue letter from Medicare telling you that they were moving you from the drug plan you were originally assigned to because either 1) that plan was leaving the Medicare program on December 31, <current calendar year>, or 2) the cost for that plan was increasing beginning January 1, <following calendar year>.

As of January 1, <following calendar year>, you should begin using <PDP name> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy, except in an emergency, <PDP name> may not pay for your prescriptions.

[*Optional:* You can use this letter as proof of your prescription drug coverage when you go to the pharmacy until you get your Member ID card from us**.**]

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

- <insert $0 per month for your <PDP name> premium, [for LIS individuals with 100% premiums subsidy] OR
- <insert applicable LIS copay/coinsurance amount that will be charged in following calendar year> when you fill a prescription.

If you believe this is incorrect and you have proof that that the extra help amounts should be different, please contact customer service.

You aren't required to be in <PDP name>. If you want to join a different Medicare prescription drug plan, call that plan to find out how to join. If you don't want Medicare prescription drug coverage at all, call <PDP name> at <phone number>. TTY users should call <TTY number>. We are open <days/times> of operation and, if different, <TTY hours of operation>. You will need to tell us you don't want Medicare prescription drug coverage.

Thank you.

## Exhibit 30: Optional Notice for "Losing Plan" to LIS Beneficiaries Re-Assigned to a Different PDP Sponsor (in lieu of ANOC)

Dear < Member>:

Recently Medicare sent you a blue letter telling you that they will switch you to another Medicare drug plan starting January 1, <following calendar year>. This is because it will cost you more if you stay in <PDP name>.

The letter also said that you can stay in <PDP name> in <following calendar year>. However, if you stay with us, you will pay a higher monthly premium in <following calendar year>. If you want more information to help you decide, please call our <PDP name> <days and hours of operation>, at <customer service toll-free number>. TTY users should call <TTY number> for the hearing impaired. We will send you more information about the following:

- How your monthly premium would change for <following calendar year>
- How your benefits and costs would change for <following calendar year>
- What to do if your drug in <following calendar year> is no longer on the formulary or is more expensive

If you would like this information to help you decide or if you want to stay in <current plan>, call and let us know as soon as possible.

You can also get information about the Medicare Program and Medicare drug plans by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare customer service representatives are available, 24 hours a day, seven days a week, to answer questions about Medicare.

**If you do nothing, your membership with us will end on December 31,** <current calendar year>**. You will get information from your new plan telling you about your benefits and any costs for <following calendar year>.**

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

Thank you.

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

## Exhibit 31: Enrollment Status Update -- For use with Transaction Reply Codes (TRC) from User Interface (UI) changes

**[**Member #**]**

<Date>

Dear < Member>:

Your enrollment in <PDP name> has been updated.

[*Insert one or more of the following, including sufficient detail, to describe the specific enrollment change:*

- You have been enrolled in <PDP name>. Your coverage will start on <*start date*> and will end on <*end date*>. [*Insert information about premiums, if applicable, and how to access coverage, etc*.].
- Your enrollment in <*old PBP name*> has been changed to <new PBP name>. Your coverage in <*new PBP name*> will start on <*date*>. [*Insert information on premium differences (if any), cost sharing information, and other details the individual will need to ensure past and future coverage is accessible and clear*].
- Your enrollment in <PDP n*ame*> started on an earlier date. Your coverage will start <*date*>. [*Include information about premiums and coverage here*]
- Your enrollment in <PDP n*ame*> has been changed to start on a later date. Your coverage with <PDP n*ame*> will start on < *date*>. [*Insert information about refunding premium, where applicable, and impact to paid claims*]
- Your enrollment in <PDP n*ame*> ended on < *date*>. This means you won't have coverage from <PDP n*ame*> after <*date*>. [*Insert appropriate descriptive information, such as premium owed if the date has moved forward, or premium refunds if the date has moved back, and impact on paid claims or how to submit claims, as applicable*].
- Your enrollment in <PDP n*ame*> has been cancelled. This means that you don't have coverage from <PDP n*ame*>. [*Insert information about refund of premium, if applicable, and impact to any paid claims*].
- [*Insert other pertinent and appropriate information regarding the enrollment status update and the resulting impact to the beneficiary as necessary*.]

Call <PDP name> at <toll-free number> <days and hours of operation> if you have any questions or want more information. TTY users should call <toll-free TTY number>.

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

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

## Exhibit 32: Model Employer/Union Sponsored Prescription Drug Plan Group Enrollment Mechanism Notice

<Date>

Dear (name)

<Name of Employer or Union> is enrolling you in <name of PDP> as your retiree prescription drug plan beginning <effective date>, unless you tell us by <insert date no less than 21 days from the date of notice> that you don't want to join our plan. <Plan name> is a Medicare Prescription Drug (Part D) plan. This enrollment will automatically cancel your enrollment in a different Medicare Prescription Drug (Part D) plan or a Medicare Advantage plan. Please call us if you think you might be enrolled in a different Medicare Prescription Drug plan or a Medicare Advantage plan.

**What do I need to know as a member of <PDP name>?**
This mailing includes important information about <PDP name> and the coverage it offers, including a summary of benefits document. Please review this information carefully. If you want to be enrolled in this Medicare prescription drug plan, you don't have to do anything, and your coverage will start on <effective date>.

Once you are a member of <PDP name>, you have the right to appeal plan decisions about payment or services if you disagree. Read the <insert either Member Handbook or Evidence of Coverage document> from <PDP name> when you get it to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

<PDP Name> is a Medicare drug plan and is in addition to your coverage under Medicare Part A or Part B. Your enrollment in <PDP name> doesn't affect your coverage under Medicare Part A or Part B. It is your responsibility to inform <PDP name> of any prescription drug coverage that you have or may get in the future. You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, your enrollment in <PDP name> will end that enrollment. Enrollment in <PDP plan> is generally for the entire year.

By joining this Medicare prescription drug plan, you acknowledge that <PDP Name> will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that <PDP Name> will release your information, including your prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

**What happens if I don't join <PDP name>?**
You aren't required to be enrolled in this plan. <insert information about other group sponsored plan options, if there are any>. You can also decide to join a different Medicare drug plan. You can call 1-800-MEDICARE (1-800-633-4227) 24 hours per day, 7 days per week for help in learning how. TTY uses should call 1-877-486-2048. However, if you decide not to be enrolled <insert consequences for opting out of group plan, like that you cannot return, or that other benefits are impacted>.

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

**What should I do if I don't want to join <PDP name>?**
To request not to be enrolled by this process <insert clear instruction for opting out, including telephone numbers and days/hours of operation>.

**What if I want to leave <PDP name>?**
Medicare limits when you can make changes to your coverage. You may leave this plan only at certain times of the year or under certain special circumstances. To request to leave, call <PDP name>.

<PDP name> serves a specific area. If you move out of the area that <PDP Name> serves, you need to notify us so you can disenroll and find a new plan in your area.

Keep in mind that if you leave our plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may have to pay a late enrollment penalty in addition to your premium for Medicare prescription drug coverage in the future.

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

Thank you.

## Exhibit 33: PDP Model Notice to Research Potential Out of Area Status

<Date>
<Member ID>

Dear <member name>:

We have recently received information that your address may have changed and that you may not live inside the service area of <plan name>. **If you don't contact us to verify your address, you will be disenrolled from <plan name> effective <disenrollment effective date>.**

It is important that you contact us to verify your permanent address. You may use this form and return it to us in the enclosed envelope or you may call our <Customer Service, Member Services> department at <phone number><days and hours of operation>. TTY users should call <TTY number>.

Please note that your permanent address must be inside our service area in order for you to be a member of <plan name>. You may request that we send mail to you at another address outside of our service area. You may also temporarily reside for up to 12 months outside our service area and remain a member of <plan name>. But if you permanently move outside our service area or if you temporarily live outside our service area for more than 12 months in a row, we must disenroll you from <plan name>. You will have an opportunity to enroll in a plan that serves the area where you now live.

**Your Permanent Address**
Please tell us the permanent address where you live. Don't use a post office box.

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number: _____

**Your Temporary Address**
If you are currently living somewhere other than your permanent address, please provide the address. Don't use a post office box. (You may skip this section if you are living at your permanent address.)

Street: _____
City, State, ZIP: _____
County: _____
Current Phone Number: _____
When did you begin living at this address? _____
When do you expect to return to your permanent address? _____

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

**Your Mailing Address**
If the address that you want us to use to send information to you is different than your permanent address, please provide it below. (You may skip this section if your mailing address is the same as your permanent address that you provided.)

Street or P.O. Box: _____
City, State, ZIP: _____
County: _____
Current Phone Number: _____

If you have moved and haven't told the Social Security Administration (SSA) about your new address, you may call them at 1-800-772-1213 (TTY 1-800-325-0778) Monday-Friday, 7am to 7pm.

If you have any questions or need help, please call us at the <Customer Service, Member Services> phone number listed above.

Thank you.

## Exhibit 34: PDP Model Notice for Disenrollment Due Out of Area Status (No Response to Request for Address Verification)

<Date>
<Member ID>

Dear <member name>:

On <date of notice requesting address verification> we asked you to contact us so that we could determine whether you had moved out of the [*Optional:* <Parent Organization Name>] <plan name> service area. As we explained in our earlier letter, in order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to 12 consecutive months.

Our records show that you haven't responded to our earlier letter. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.** Beginning <effective date>, <plan name> won't cover your prescription drugs.

**This letter pertains only to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits aren't affected by your disenrollment from < PDP name >.**

**What if I disagree with this decision?**
You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

**Can I enroll in a new plan?**
You may have up to two months to join a new Medicare Prescription Drug Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048) for information about plans that may serve your area.

If you don't enroll in a Medicare Prescription Drug Plan during this special two-month period, you may have to wait to enroll in a new plan. Medicare limits when you can enroll in a new Medicare Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO). From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

**What happens if I don't enroll in another Medicare Prescription Drug Plan?**
Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you

may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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

**What should I do if I've moved?**
If you have moved and haven't notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

**What should I do if I have more questions?**
If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

## Exhibit 35: PDP Notice of Disenrollment Due to Out of Area Status (Upon New Address Verification from Member)

<Date>
<Member ID>

Dear <member name>:

Thank you for informing us of your recent change of permanent address. Your permanent address is now outside the <plan name> service area. In order to be a member of our plan, you must live in the <plan name> service area, although you may be out of the service area temporarily for up to 12 consecutive months. Therefore, **you will be disenrolled from <plan name> effective <disenrollment effective date>.** Beginning <effective date>, <plan name> won't cover your prescription drugs.

**This letter pertains only to your Medicare Prescription Drug Plan benefits. Your other Medicare benefits aren't affected by your disenrollment from < PDP name >.**

**What if I disagree with this decision?**
You have the right to ask us to reconsider this decision. You can ask us to reconsider by filing a grievance with us. Look in your <EOC document name> for information about how to file a grievance.

**Can I enroll in a new plan?**
You may have up to two months to join a new Medicare Prescription Drug Plan that serves the area where you now live. You may call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048) for information about plans that may serve your area.

**What if I don't enroll in a new plan right now?**
If you don't enroll in a Medicare Prescription Drug Plan during this special two-month period, you may have to wait to enroll in a new plan. Medicare limits when you can enroll in a new Medicare Prescription Drug Plan or in a Medicare Health Plan (such as an HMO or PPO). From October 15 through December 7 each year, you can join, switch or drop a Medicare health or drug plan for the following year. Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

**What happens if I don't enroll in another Medicare Prescription Drug Plan?**
Please remember, if you don't enroll in another Medicare Prescription Drug Plan (or a Medicare Advantage Plan with prescription drug coverage) or you don't have or obtain other coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage"), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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

**What if my premium was being deducted from my Social Security/Railroad Retirement Board benefit check?**
If your Medicare Part D premium is being deducted from your Social Security or Railroad Retirement Board benefit, please allow up to 3 months for us to process a refund. If you haven't received a refund from Social Security/the Railroad Retirement Board within 3 months of this letter, you should contact 1-800-MEDICARE.

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

**What should I do if I've moved?**
If you have moved and have not notified Social Security of your new address, you may call them at 1-800-772-1213 (TTY: 1-800-325-0778) Monday-Friday, 7am to 7pm.

**What should I do if I have more questions?**
If you have any questions or need help, please call our <Customer Service, Member Services> department at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

## Exhibit 36: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration

<Date>

Dear <Beneficiary Name>:

Medicare has disenrolled you from <plan name> because its records show that you are incarcerated. As of <effective date>, you no longer have coverage through <plan name>. Your Medicare prescription drug coverage ends on this date. You will have Original Medicare; however, Medicare generally doesn't pay for your hospital or medical bills if you're incarcerated. If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, based on information from SSA, not by <plan name>.

**What if I think there's been a mistake?**
If you aren't incarcerated or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

**What happens to my Medicare and Part D coverage?**
While you are incarcerated, you are not eligible to enroll in a Medicare health or Part D plan. However, once you are released and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. *This opportunity begins the month you are released and lasts for two additional months.* If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as if you move out of your plan's service area, you want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after your release, you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

**Who can I call to get more information?**
You can call Social Security at 1-800-772-1213, if you have questions about your incarcerated status. TTY users should call 1-800-325-0778. If you have questions about your Medicare coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.

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

## Exhibit 37: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence

<Date>

Dear <member name>:

Medicare has disenrolled you from <plan name> because the Social Security Administration (SSA) reported that you are not lawfully present in the United States. As of <effective date>, you no longer have coverage through <plan name>. Your Medicare prescription drug coverage ends on this date. You will have Original Medicare; however, Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S.

If your plan premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter.

The decision to disenroll you was made by Medicare, based on information from SSA, not by <plan name>.

**What if I think there's been a mistake?**
If you aren't unlawfully present in the U.S. or think that there has been a mistake, please call us at <phone number>. TTY users should call <TTY number>. We are open <days and hours of operation>.

**What happens to my Medicare and Part D coverage?**
While you are unlawfully present in the United States, you are not eligible to receive any coverage in the Medicare program. This includes coverage through Original Medicare, a Medicare health plan or Medicare prescription drug coverage. If you become lawfully present in the U.S. in the future and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. This opportunity begins the month you regain lawful presence status and last for two additional months. If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after you become lawfully present in the U.S., you may have to pay a lifetime Part D late enrollment penalty in addition to any plan premium, if you enroll in Medicare prescription drug coverage in the future.

**Who can I call to get more information?**
You can call Social Security at 1-800-772-1213, if you have questions about your lawful presence status. TTY users should call 1-800-325-0778. If you have questions about your Medicare coverage, you can call 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day,

7 days a week.  TTY users should call 1-877-486-2048. You can also call < plan name> at <phone number> if you have questions. TTY users should call <TTY number>. We are open <days and hours of operation>.

Thank you.