

Medicare Managed Care Manual

Chapter 17, Subchapter D Medicare Cost Plan Enrollment and Disenrollment Instructions

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This guidance update is effective for contract year 2021. All enrollments with an effective date on or after January 1, 2021, must be processed in accordance with the revised requirements, including new model enrollment forms and notices, as appropriate. Cost organizations may, at their option, implement any new requirement consistent with this guidance (e.g. new model forms/notices) prior to the required implementation.

It is expected that cost organizations will assure compliance with all cost plan requirements described in this subchapter regarding communications made with beneficiaries/members, including the use of the model notices and the requirements outlined in the Medicare Communications and Marketing Guidelines (MCMG).

Organizations are required to provide information to individuals in accessible/alternate formats (for example, Large Print, Braille), upon request and thereafter, as outlined in Section 504 of the Rehabilitation Act of 1973 (and subsequent revisions). Such individuals must have an equal opportunity to participate in enrollment, paying premium bills, and communicating with the plan, as members who do not request accessible/alternate formats.

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10 – General Information

10.1 – Definitions

42 CFR 417.1

Application Date – For paper enrollment forms and other enrollment request mechanisms, the application date is the date the enrollment request is initially received by the Medicare cost plan as defined below. Cost plans must use this date in the appropriate field when submitting enrollment transactions to CMS.

- For requests sent by mail, the application date is the date the application is received by the cost plan (i.e., arrives in the cost plan’s mailbox or mailroom); the postmark is irrelevant.
- For requests received by fax, the application date is the date the fax is received on the cost plan’s fax machine.
- For requests submitted to sales agents, including brokers, the application date is the date the agent and/or broker receives (accepts) the enrollment request and not the date the cost plan receives the enrollment request from the agent and/or broker. For purposes of enrollment, receipt by the agent or broker, employed by or contracting with the cost plan, is considered receipt by the plan, thus all CMS required timeframes for enrollment processing begin on this date.
- For requests accepted by approved telephonic enrollment mechanisms, the application date is the date of the call. The call must have followed the approved script, included a clear statement that the individual understands he or she is requesting enrollment, and have been recorded.
- The Medicare.gov Online Enrollment Center (OEC) uses Coordinated Universal Time (UTC, which was formerly known as Greenwich Mean Time and is four hours ahead of Eastern Daylight Time and five hours ahead of Eastern Standard Time) as the system time to generate the timestamp of when an enrollment was received. For requests made via the OEC, the application date to be used for processing the enrollment request is the time and date that is 11 hours earlier than the time and date CMS “stamps” on the enrollment request at the time the individual completed the OEC process. This is true regardless of when the cost plan ultimately retrieves or downloads the request.

Example: An individual completes an enrollment request and submits it via the OEC at 9:00 p.m. EST on December 7. The OEC will “stamp” this request as having been completed on December 8 at 2:00 a.m., which is the UTC equivalent time and date. The organization will use December 7, 3:00 p.m., as the application date for the purpose of addressing CMS enrollment policy requirements (e.g. application date, determination of election period, etc.).

- For electronic enrollment requests made using the cost plan’s system instead of the OEC, the application date is the date the applicant completes the request through the cost plan’s electronic enrollment process. This is true regardless of when a cost plan ultimately retrieves or downloads the request.

- For all enrollments into employer group or union sponsored plans, the application date used on the transaction submitted to CMS will always be the first of the month prior to the effective date of enrollment for all mechanisms at all times. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the cost plan receives the request. For example, if a valid group enrollment mechanism file is received by the cost plan on January 24th for enrollments effective February 1st, the receipt date for the provision of required notices is January 24th and the application date submitted on the enrollment transactions is January 1st.
- For auto- or facilitated enrollment as provided in Section 40.1.5, the application date is the first day of the month prior to the effective date of the auto/facilitated enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the auto- or facilitated enrollment in CMS systems.

At-risk Beneficiary – A part D eligible individual who is determined to be at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at *42 CFR* 423.153(f). Additional guidance about Part D drug management programs is available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.html
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Conversions – For individuals who are enrolled in a health plan offered by the Medicare cost plan the month immediately before the month of their entitlement to Medicare Parts A and B, or Part B only, their enrollment in a cost plan offered by the same organization is referred to as a “conversion” from commercial status to Medicare cost enrollee status. The effective date of conversion enrollments is the first of the month of initial Medicare entitlement.

Enrollment Request Mechanism – A method used by individuals to request to enroll in a Medicare cost plan.

Evidence of Medicare Part A and/or Part B Coverage – Documentation, materials or other information that confirms an individual is entitled to coverage under Parts A and B of Medicare. Evidence of entitlement is a requirement to determine eligibility for enrollment into a Cost plan. It includes the individual’s coverage start dates for Part A and Part B. CMS systems are updated within two business days of SSA processing a new or changed Part A or Part B entitlement. Medicare cost plans must verify Medicare entitlement for all enrollment requests using either the BEQ or the MARx online query (M232).
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

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

Good Cause – This term refers to the standards established in §60.6.3 under which an individual may be reinstated into his or her cost plan, or optional supplemental Part D benefit, when involuntarily

disenrolled for failure to pay the plan's premium (or other charges, such as deductible, co-insurance, etc.) or the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA).

Incarceration – This term refers to the status of an individual who is in the custody of a penal authority and confined to a correctional facility, such as a jail or prison, or a mental health institution as a result of a criminal offense. Such individuals reside outside of the geographic service area for the purposes of cost plan eligibility, even if the correctional facility is located within the organization's geographic service area. Individuals who are confined to Institutions for Mental Disease (IMDs), such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, as a result of violations of the penal code, are incarcerated as CMS defines the term for the purpose of cost plan eligibility. The place of residence for these confined individuals is therefore excluded from the service area of a cost plan on that basis.

Individuals who are confined to IMDs, such as state hospitals, psychiatric hospitals, or the psychiatric unit of a hospital, for other reasons (e.g., because of court orders unrelated to penal violations) are not incarcerated. Normal service area rules apply to these individuals.

Involuntary Disenrollment – Disenrollments made based on the cost plan's determination that the individual is no longer eligible to remain in the plan, or when a cost organization otherwise initiates disenrollment as allowed in this guidance (e.g. failure to pay plan premiums, plan termination).

Lawfully Present Individual – Refer to 8 C.F.R. 1.3 (Lawfully present aliens for purposes of applying for Social Security benefits) for a definition of an alien who is considered lawfully present in the United States. An individual who is not lawfully present in the United States is not eligible for any federal public benefit, including payment of Medicare benefits. (8 U.S.C. 1611)

Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA) – A premium amount, separate from the Part D plan's monthly premium, for individuals whose incomes meet specific thresholds. The Social Security Administration assesses the amount annually based on the enrollee's available tax information. The plan does not collect the Part D-IRMAA as part of its premium. Typically, individuals pay the Part D-IRMAA through their Social Security, Office of Personnel Management or Railroad Retirement Board (RRB) benefit withholding. Some enrollees are directly billed for their Part D-IRMAA through invoices sent by CMS or the RRB. All Part D enrollees who are assessed the Part D-IRMAA are required to pay the IRMAA, even if the Part D coverage is provided through an EGHP.

Plan Performance Rating – A CMS-assigned rating, measured in stars from one to five, which indicates an organization's quality and performance based on criteria established by CMS. A star rating of one star indicates poor performance, while a star rating of five stars indicates exemplary performance. The Plan Performance Overall Rating (or "overall rating") is publicly available on Medicare.gov. CMS assigns the rating in October for the following year based on the organization's most recent quality and performance data.

Potential At-risk Beneficiary – A Part D eligible individual who is identified as being potentially at-risk for misuse or abuse of a frequently abused drug in accordance with the requirements for drug management programs at [42 CFR 423.153\(f\)](#). Additional guidance about Part D drug management programs is available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxUtilization.htm

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Receipt of Enrollment Request – Medicare cost organizations may receive enrollment requests through various means, as described in § 40.1. The Medicare cost plan must date as received all enrollment requests as soon as they are initially received. This date will be used to determine the effective date of the request. Please refer to the definition of “Application Date” in this section for specific information regarding the correct date to report as the application date on enrollment transactions submitted to CMS.

Voluntary Disenrollment – Disenrollment initiated by a member or his or her authorized representative.

10.2 – General Requirements

42 CFR 417

Cost contracts generally are limited to existing contractors, who had a cost contract in place before the date of enactment of the Balanced Budget Act of 1997. The only exception to this rule is for entities that currently have an HCPP contract under §1833(a)(1)(A) of the Social Security Act (the Act), and wish to convert to a §1876 cost contract. In order for an HCPP to contract CMS under a cost contract, the entity must meet certain qualifying conditions as outlined in 42 CFR 417, Subpart J. One of these qualifying conditions requires the entity to demonstrate an ability to enroll members and to sustain a membership that ensures effective, efficient and economical care to the plan's Medicare enrollees. Meeting these requirements is also a condition for continuing to contract with CMS as an existing cost contractor.

Operating experience and enrollment requirements are minimum standards. In addition to the plan demonstrating the ability to enroll members, these enrollment levels are necessary to provide a reasonable basis for CMS to establish payment rates for the plan.

10.3 – Cost Plans Offering Medicare Prescription Drug Coverage as an Optional Supplemental Benefit

42 CFR 417.102

Individuals enrolled in (or newly enrolling in) a cost plan may select that cost plan's optional supplemental Medicare prescription drug benefit (Part D), if one is offered, following the requirements outlined in Chapter 3 of the Medicare Prescription Drug Benefit Manual. It is important to remember that even though a cost plan is not subject to the Part D enrollment periods, these enrollment periods apply to a cost plan member's (or new enrollee's) ability to enroll in or disenroll from the optional supplemental Part D benefit.

Individuals enrolled in a cost plan, regardless of whether or not the cost plan offers an optional supplemental Part D benefit, may enroll in a separate Prescription Drug Plan (PDP), during applicable enrollment periods and in accordance with CMS Part D eligibility and enrollment guidance. Such individuals will be simultaneously enrolled in both the cost plan (but not the cost plan's optional supplemental Part D benefit) and the separate PDP.

Cost plans offering the optional supplemental Part D benefit must determine if the Part D late enrollment penalty (LEP) applies, following guidelines in Chapter 4 of the Medicare Prescription Drug Benefit Manual. If so, cost plans must apply the LEP amount reported by CMS to the member's monthly premium.

An individual in a cost plan with an optional supplemental Part D benefit may be subject to a Part D- Income Related Monthly Adjustment Amount (IRMAA). The Part D-IRMAA is paid directly to the government and not to the plan. Individuals who fail to pay the Part D-IRMAA within the established grace period will be involuntarily disenrolled. See Section 50.7.5.

20 – Eligibility for Enrollment in a Medicare Cost Plan

42 CFR 417.422

(Rev. 1, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

In general, an individual is eligible to enroll in a cost plan by meeting each of the following requirements. A cost plan that is accepting new members must enroll any Medicare beneficiary who:

- Is entitled to benefits under Medicare Part A and enrolled in Medicare Part B, or is enrolled in Medicare Part B only;
- Is a U.S. citizen or lawfully present in the United States (see exceptions in §20.4 for persons unlawfully present at the time of the enrollment request);
- Permanently resides within the geographic area of the cost plan (see exception in §20.1 for persons converting to Medicare Part A and/or Part B who are living outside the service area at the time of enrollment and see definition in §10 for persons who are incarcerated);
- Completes the application form or mechanism used to enroll members during the enrollment period and provides all the information required to process the enrollment; and
- Agrees to abide by the rules *of the cost plan*.

A cost plan must deny enrollment if:

- The beneficiary has been medically determined to have End Stage Renal Disease (ESRD) prior to applying for enrollment (with some exceptions; see §20.2).
- The beneficiary is otherwise ineligible to enroll in the cost plan
- CMS has granted a waiver or limitation of the open enrollment requirement (see §30.1.1) and that limit has been reached

Individuals who have elected Hospice are not precluded from enrolling in a Cost plan per the statutory eligibility criteria in Section 1876(d) of the Social Security Act.

A cost plan may choose to wait for the individual's payment of the plan premium, including any premiums or cost sharing due the organization for a prior enrollment, before processing the enrollment.

The organization may not deny enrollment to a Medicare beneficiary who continues to work and who is enrolled in his or her employer's health benefits plan (or that of a spouse). If the individual enrolls in a cost plan and continues enrollment in his or her (or their spouse's) employer health benefits plan, then coordination of benefits rules apply.

If the cost plan offers Medicare prescription drug coverage as an optional supplemental benefit, current cost plan members, as well as individuals newly enrolling in the cost plan, may select this benefit only during Medicare prescription drug coverage enrollment periods, as described in Chapter 3 of the Medicare Prescription Drug Benefit Manual.

Individuals enrolled in a Medicare Advantage (MA) plan must have a valid MA election period available that would permit their disenrollment from that MA plan upon enrollment into a cost plan (MA election periods are described in detail in the CMS MA enrollment and disenrollment guidance).

Enrollment into a cost plan by an individual who is currently an MA enrollee requires a valid MA enrollment election period type on the cost plan enrollment transaction to effectuate the individual's disenrollment from the MA plan upon enrollment into the cost plan.

20.1 – Conversion Enrollments

42 CFR 417.432

The cost plan must accept as a Medicare member any individual who was enrolled in the organization during the month immediately before the month in which he or she became entitled to both Medicare Parts A and B, or Part B only. The individual must complete an application form or other enrollment request mechanism within the standard timeframes. The application of this provision to individuals with ESRD is discussed in §20.2.2.

Unless the individual chooses to cancel the enrollment request in the Medicare cost plan, the effective date of the conversion is the month in which he or she is entitled to Medicare Parts A and B or Part B only. The Medicare cost organization may not cancel the enrollment of an individual who is converting unless one of the conditions specified in 50.2 or 50.3 applies.

The cost plan has the option to also allow individuals who are newly entitled to Medicare Parts A and/or B to elect the cost plan upon conversion even if they reside outside the service area. The cost plan must apply its choice of this option consistently for all individuals. These members will be known as “out-of-area” members. This option applies both to individual members and employer group members of the cost plan. Individuals permitted to enroll under this option must also be permitted to enroll in the cost plan’s optional supplemental Part D benefit, if one is offered. A cost plan that is closed to enrollment cannot accept conversion enrollments.

20.2 – End Stage Renal Disease

42 CFR 417.423

Generally, an individual is not eligible to enroll in a cost plan if he or she has been medically determined to have ESRD (see exceptions described under §20.2.2). End Stage Renal Disease (ESRD) is defined as that stage of kidney impairment that appears irreversible and permanent, and requires a regular course of dialysis or a kidney transplant to maintain life.

An individual who receives a transplant that restores kidney function and no longer requires a regular course of dialysis to maintain life is no longer considered to have ESRD for purposes of cost plan eligibility. The individual may elect to enroll in a cost plan if he or she meets the other applicable

eligibility requirements indicated in §20. If a beneficiary is only eligible for Medicare on the basis of ESRD (i.e., not based on disability or age), he or she would only be permitted to remain enrolled in a cost plan during his or her remaining months of Medicare eligibility. See §40.3 for additional information.

The cost plan is permitted to ask whether the beneficiary has ESRD at the time of application. This question is permissible since the law does not permit a person with ESRD to join a cost plan. If the applicant answers “yes” to the question of whether he or she requires regular maintenance dialysis, the plan can deny enrollment after ensuring the beneficiary is not eligible for one of the exceptions listed in §20.2.2. CMS will reject the enrollment if Medicare records indicate the applicant has ESRD.

20.2.1 – Background on ESRD Entitlement

42 CFR 406.13

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

- The first day of the third month after the month dialysis begins (i.e., the first day of the fourth month of dialysis);
- The first day of the month dialysis began if the individual trains for self-dialysis;
- The month an individual is admitted to a hospital for a kidney transplant or for health care services needed before a transplant if the transplant takes place in the same month or within the 2 following months;
- Up to 12 months prior to the month of filing (if dialysis began more than 12 months before);
or
- Prospectively.

The Medicare entitlement date is usually the month an individual is hospitalized for a transplant or 3 months after the month the individual begins dialysis (i.e., the first day of the fourth month of dialysis). For example, if an individual begins dialysis in January, Medicare entitlement is effective April 1.

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

20.2.2 – Exceptions to Eligibility Rule for Individuals with ESRD

42 CFR 417.423(a)(2)

- Conversion: Individuals who developed ESRD while a member of a health plan offered by an organization and who are converting to Medicare Parts A and B, or Part B only, may enroll in a cost plan in the same organization (within the same state, with exceptions) at the time of conversion. The individuals must meet all other cost plan eligibility requirements and must fill out an enrollment form to enroll.

If a Medicare entitlement determination is made retroactively, an individual has not been provided the opportunity to elect a cost plan at the time of their conversion. Therefore, these individuals will be allowed to prospectively elect a cost plan offered by the organization, as long as they were in a health plan offered by the same organization the month before their entitlement to Parts A and B, or Part B only, developed ESRD while a member of that health plan, and are still enrolled in that health plan. This would also be allowed in cases when there is an administrative delay and the entitlement determination is not made timely. For example, an individual who performs self-dialysis will have his or her entitlement date adjusted to begin at the time of dialysis, rather than the customary third month after the month dialysis begins.

- If the individual was first medically determined to have ESRD after the date on which the enrollment form was signed but before the effective date of coverage, he can still enroll in that cost plan
- An individual who develops ESRD while enrolled in a cost plan may continue to be enrolled that cost plan. This also can apply to an individual who developed ESRD while enrolled with the organization offering the cost plan, even if the individual was not enrolled under the cost contract, and it is not a conversion situation
- An individual with ESRD who is a member of a cost plan may enroll in other plans offered by that organization (within the same state, with exceptions)
- An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of cost plan eligibility (see §40.3 for additional instructions).

20.3 – Hospice

42 CFR 417.423

Individuals who have elected Hospice are not precluded from enrolling in a Cost plan per the statutory eligibility criteria in Section 1876(d) of The Social Security Act. When it is determined that a current member of the cost plan has elected to receive hospice care, he or she must waive the right to receive treatment for the terminal condition and related conditions from any provider other than the hospice and the attending physician. **The individual cannot be disenrolled from the cost plan merely because he or she has elected hospice care.**

The beneficiary remains in the cost plan as long as he or she continues payment of the plan premium. This means that the cost plan must provide those services that have not been waived, e.g., the cost plan must continue providing services unrelated to the terminal condition that the cost plan provides or authorizes. The cost plan must also continue to provide services unrelated to the terminal condition under the same conditions that would apply to a member who has not elected hospice (the member continues to be responsible for normal plan cost sharing for these services), and any supplemental benefits for which the beneficiary has paid.

Upon revocation of the hospice election or when the enrollee exhausts his or her hospice benefits, the cost plan must immediately reinstate the beneficiary's full enrollment.

20.4 – U.S. Citizenship or Lawful Presence Status

An individual is eligible to elect enrollment in a cost plan if he or she is a U.S. Citizen or lawfully present in the United States. CMS will notify the cost organization if the individual is not eligible to enroll on this basis at the time of enrollment. The cost organization must deny an enrollment request from an individual who does not meet this requirement.

EXCEPTION: In the case where CMS systems show that an individual will have lawful presence status on or before the enrollment effective date, the plan must accept and process the enrollment request. A cost organization must not deny an enrollment request on the basis that the applicant is not lawfully present at the time the request is received if CMS systems indicate that he or she will be lawfully present in the United States as of the enrollment effective date.

If an individual provides evidence of their lawful presence status to the cost organization, the organization may not consider it when determining eligibility for enrollment. The organization may not request from an applicant any documentation of U.S. citizenship or alien status. CMS will provide the official status to the cost organization at the time of enrollment. However, if an individual has evidence of their lawful presence status and there is a dispute over their status, the cost organization should refer the individual to the Social Security Administration to have their status reviewed and adjusted, if necessary.

30 – Enrollment Periods and Effective Date of Enrollment

42 CFR 417.422

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Cost plans are subject to the following requirements to accept enrollment forms from individuals eligible to enroll in the cost plan. Individuals wishing to also enroll in an optional supplemental Part D benefit offered by the cost plan may do so only during applicable Part D enrollment periods (refer to section 10.2). For Part D enrollment periods, see Chapter 3 of the Medicare Prescription Drug Manual.

30.1 – General Open Enrollment Requirements

42 CFR 417.426

The general requirements for open enrollment are that the cost plan:

- Hold an annual open enrollment period of at least 30 or more consecutive days for Medicare beneficiaries;
- Publicize its upcoming enrollment period in appropriate media throughout the service area (this requirement does not apply for Cost Plans that are continuously open for enrollment); and
- Enroll Medicare beneficiaries on a first come, first serve basis.

If the organization has met the 30-day requirement through a longer enrollment period or through continuous open enrollment and it decides to close enrollment, the plan must notify CMS and the general public 30 days in advance of the new limitations on its open enrollment process (refer to Exhibit 12).

If the organization has both a cost contract and a Medicare Advantage contract in the same service area, it may not enroll new individuals in the cost plan (42 CFR 422.503(b)(5)).

This prohibition on enrolling new individuals in the cost plan also applies to enrollments into employer or union sponsored cost plans, including individuals who convert to Medicare (either by age or disability). While CMS has granted exceptions to this prohibition on a limited basis in the past, any such exceptions ended on December 31, 2009. As of this date, all employer/union sponsored cost contracts will be prohibited from accepting enrollments.

The cost plan would not be able to retain its Medicare Advantage contract if it were to accept new enrollments in the cost plan at any time of the year. In this instance only, CMS will not enforce the cost plan's obligation to open enrollment. The cost plan must always accept requests for disenrollment.

If a cost plan is voluntarily closed for enrollment, then it is closed to all individuals in the entire plan service area for enrollment. When a cost plan re-opens after being voluntarily closed, there is no requirement for the cost plan to notify the general public. However, the cost plan should notify CMS when this occurs. If this occurs, the plan would no longer be able to offer a Medicare Advantage contract in the area.

A cost plan that offers an optional supplemental Part D benefit must permit plan members to enroll in or disenroll from that benefit during any valid Part D enrollment period, as described in Chapter 3 of the Medicare Prescription Drug Benefit Manual, regardless of whether the cost plan is otherwise open for enrollment.

A cost plan that offers an optional supplemental Part D benefit can allow plan members to make changes to their medical (non-prescription) benefits during the general open enrollment period, but those members cannot make changes to their Part D benefit unless a valid Part D enrollment period exists for the member.

30.1.1 – Waivers for Open Enrollment

The organization may obtain a waiver of the open enrollment requirements under one of the following two conditions - (1) Non-representative enrollment, and (2) Limited capacity.

Non-Representative Enrollment

42 CFR 417.413(e)(2)

An open enrollment period will result in a membership substantially non-representative of the population in the geographic area. In this case, the organization may request a selection restriction in writing at least 90 days before the proposed open enrollment period. The organization must provide statistical data that an open enrollment period would cause a particular membership subgroup to exceed its proportion of the geographic area by at least 10 percent. A subgroup is defined as a class of Medicare beneficiaries based on factors such as age, gender, or other factors that CMS determines significantly affects health care utilization. The organization may not limit enrollment unless and until CMS approves the selection policy. If the organization submits insufficient data to make a decision, CMS will deny the request.

Limited Capacity

42 CFR 417.426(b)

The organization does not have capacity for additional members, or the organization must limit enrollment to a certain number of members. The organization must estimate whether it would reach capacity during its next open enrollment period, and would therefore need a CMS approved capacity waiver. The following sections describe criteria and procedures for capacity waiver applications. An organization must submit all required information to its Regional Office at least (and preferably more than) 90 days prior to the open enrollment period for Medicare beneficiaries. CMS will make every attempt to notify the organization of its decision at least 60 days in advance of the enrollment period. If the waiver is granted, it remains in effect for one year only.

30.1.2 – Determining Enrollment Availability for Medicare Beneficiaries

42 CFR 417.426(c)

The cost plan must verify to CMS the number of vacancies open to Medicare beneficiaries during the open enrollment period. If there are conditions or factors that the organization believes are pertinent to determining its enrollment availability for Medicare beneficiaries, it should submit this information to CMS. Utilizing a worksheet (Appendix 2), the plan will determine enrollment availability by:

1. Establishing present capacity;
2. Obtaining current Medicare, Medicaid, and commercial enrollment numbers;

3. Adjusting these enrollment numbers by the following figures:
 - i. Reserved vacancies -add to commercial enrollment the number of members the plan expects to enroll from its existing group contracts and from anticipated new group contracts (see §30.1.5);
 - ii. Subtract expected age-ins (commercial members of the plan who will convert to Medicare status upon becoming eligible for Medicare) from the commercial enrollment total and add to the Medicare enrollment numbers for a new Medicare enrollment total; and
 - iii. Multiply the new Medicare enrollment total by the organization's Medicare utilization factor (see §30.1.4) to obtain an adjusted Medicare enrollment total.
4. Subtracting the adjusted commercial enrollment total and the adjusted Medicare enrollment total from the organization's capacity. The remainder determines the number of vacancies available for open enrollment.

These vacancies must be filled with Medicare beneficiaries up to the point where further enrollment would be substantially non-representative of the population in the geographic area.

30.1.3 – Utilization Adjustment Factor

CMS recognizes the greater intensity of services and frequency of health care utilization among Medicare beneficiaries than among commercial membership. Since there is no one-to-one equivalence between Medicare and commercial members in this respect, a utilization adjustment factor is incorporated in calculating enrollment capacity. The utilization adjustment factor represents the number of commercial members the organization could serve for every one Medicare member served over the course of the contract year. The organization also provides backup documentation and discussion of the methodology employed in the calculations. For example, if the data show that Medicare utilization is three times that of commercial members, the capacity for new commercial members is three times what it would be for new Medicare members. Therefore, if the available capacity is for 3,000 additional commercial members in the next contract period, and the organization anticipates filling 1,500 of those slots with commercial members, the remaining 1,500 slots must be divided by three. That is, full capacity is reached if the organization enrolls 500 Medicare members in addition to the 1,500 commercial members, based on a ratio of one Medicare vacancy to every three commercial vacancies.

30.1.4 – Reserved Vacancies

42 CFR 417.426(c)

Reserved vacancies are those set aside for members of anticipated new group contracts or for anticipated new members of an existing group contract when these group enrollment periods are held after the cost plan open enrollment period.

If open enrollment(s) for one or more of the organization's group contracts is scheduled after the organization's cost plan open enrollment period, the plan should set aside a reasonable number of slots or vacancies for anticipated new members from these groups. These reserved vacancies should also be used to determine the enrollment availability for Medicare beneficiaries as described in §20.1.

Because these reserved vacancies limit the available spaces for Medicare members, CMS must approve the organization's use and number of reserved vacancies. Therefore, reserved vacancies are included in the calculations outlined in §30.1.5 and on the worksheet shown in Exhibit 12. Reserved vacancies not used within a reasonable time after the group contract enrollment period has begun must be released and made available to Medicare beneficiaries.

30.1.5 – Special Requirements When Reaching Capacity

42 CFR 417.430(b)

If an organization reaches capacity during open enrollment and it has a CMS approved waiver, it has two options: It can refuse further enrollments or continue accepting applications and place them on a waiting list. For example, if the organization opts to continue accepting applications, it must place all prospective members who wish to wait for an opening on the waiting list in chronological order. As vacancies occur, the plan should contact the beneficiary, and enroll him or her after ensuring he or she still wants the cost plan to honor the application.

30.2 – Effective Date of Enrollment in Cost Plans

42 CFR 417.450

A Medicare cost plan may choose between the following two Cost Plan Enrollment Effective date options:

1. Cost Plan Enrollment Effective Date Option 1: Follow the traditional cost plan effective date rules found below as Enrollment Effective Date Option 1 (§30.2.1)
- OR-**
2. Cost plan Enrollment Effective Date Option 2: Follow the effective date policy for enrollment outlined below as Enrollment Effective Date Option 2 (§30.2.2).

The organization must choose only one option and must apply that option to all cost plan enrollments. CMS will assume the organization will follow Cost Plan Enrollment Effective Date Option 1 unless the organization notifies (or has notified) the appropriate CMS Regional Office and includes this change in the policies and procedures provided to CMS. Organizations offering Medicare cost plans will be expected to follow the chosen enrollment effective date option throughout the contract year. CMS may permit an organization to change its enrollment effective date option during a contract year by special request for good cause. If the organization plans to change its selection of enrollment effective date options for a new contract year, it must notify the appropriate CMS Regional Office account manager.

30.2.1 – Cost Plan Enrollment Effective Date Option 1

42 CFR 417.450(a)(2)

A Medicare beneficiary's enrollment begins on the first day of the month in which his or her membership in the cost plan is effective, as shown on CMS records. The effective month of coverage may not be earlier than the first month after, or later than the third month after, the month in which the enrollment information is correctly submitted to and received by CMS. Specifically, if CMS receives the enrollment request data before the CMS monthly plan data due date, the effective date can be as early as the first of the next month and as late as the first of the third month following

receipt of the request. If CMS receives the enrollment request data after the CMS monthly plan data due date, the effective date can be as early as the first of the second month following and as late as the fourth month following the receipt of the request. See the example below. CMS may approve a later effective date if requested by the plan and the beneficiary.

Enrollment cannot be effective prior to the date entitlement to Medicare Part A and Part B, or Part B only begins. If an individual attempts to enroll in a Medicare Cost plan before becoming entitled to Medicare Part B benefits, the effective month of coverage for a valid enrollment request is the first month for which he or she becomes entitled to Medicare Part B benefits.

The cost plan is responsible for submitting accurate and timely records to CMS for new enrollments (refer to §40.2). CMS is responsible for promptly supplying systems verification of the individual's acceptance (or rejection) into the cost plan. Cost plans must adhere to and comply with the transaction submission and other systems requirements provided by CMS in the Plan Communications Users Guide.

Enrollment Effective Date Example:

The CMS monthly cut-off date for the submission of records is August 16, 2010. A cost plan enrollment application form that is received on August 12, 2010, could have an effective date of enrollment of September 1, October 1, or November 1, 2010.

If the same cost plan enrollment application form was received on August 17, 2010, (i.e., after the cut-off date for the submission of records) it could have an effective date of enrollment of October 1, November 1, or December 1, 2010.

If the cost plan has informed a beneficiary that his or her enrollment in the plan is effective on a certain date, but then submits an incorrect enrollment record to CMS, the plan must honor its contract with the individual and begin providing coverage on the stated date. If the plan provides services to the member before it can submit the correct enrollment information, the plan may still receive Medicare fee-for-service payments for any services it renders. In order for the cost plan to receive direct payments for physician and supplier services from a Medicare carrier, the cost plan must have a third party billing number, or it can have the physician or supplier bill the FFS program directly.

Additionally, if the cost plan collects or has waived collection of a premium from the beneficiary which covers the deductible and coinsurance for Medicare covered services for the originally designated month of enrollment, the cost plan is financially responsible for Medicare deductibles and coinsurance amounts not paid by carriers and intermediaries on pre-enrollment claims for services obtained in network or for emergency or urgently needed care. The Medicare beneficiary is liable for any services for which the cost plan has no financial responsibility under the terms of its Medicare contract.

30.2.2 – Cost Plan Enrollment Effective Date Option 2

Cost plans that choose this option must consistently apply the following rules:

1. **First of the Next Month:** Enrollments will be effective the first day of the month after the month the cost plan receives an enrollment form. The cost plan must be open to accept such enrollments.

2. **October 15 through December 7 of every year:** Enrollments received during this time period can be effective January 1 of the following year (except as noted below).
3. **Enrollment Prior to entitlement:** Individuals may enroll in a cost plan during the three months **immediately** before the individual's entitlement to Medicare Part A and/or Part B. The enrollment will be effective the first day of the month of entitlement to Medicare Part A and/or Part B.

Note: These rules are specific to cost plans. While they are similar to Medicare Advantage rules outlined in Chapter 2 of the Medicare Managed Care Manual, the use of Option 2 does not allow the cost plan to enroll individuals using Medicare Advantage methods and rules.

Employer group members only: Cost plans that have contracted with an employer group may offer beneficiaries enrolling through an employer group effective dates of up to three months after the month in which the cost plan receives the enrollment form. However, the effective date may NOT be earlier than the date the cost plan receives the enrollment form; retroactive transactions are not allowed.

30.2.3 – Effective Date of Optional Supplemental Part D Benefit

42 CFR 423.40

New applicants and existing cost plan enrollees who want to also enroll in an optional supplemental Part D benefit offered by a cost plan may do so only during applicable Part D enrollment periods (refer to §10.2). The effective date of this Part D benefit is determined by the Part D enrollment period. Refer to the CMS Guidance; PDP Eligibility, Enrollment and Disenrollment for additional information.

30.3 – Effect of the MA and PDP 5-Star Special Enrollment Period (SEP) on Cost Plans

42 CFR 423.38(c)(20)

(Rev. 1, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

An eligible individual may enroll in an MA plan, PDP or cost plan with an overall Plan Performance Rating of five (5) stars anytime during the year in which that plan has the 5-star overall rating, provided the individual meets the other requirements to enroll in that plan (e.g., living within the service area, as well as requirements regarding end-stage renal disease) and the cost plan is open for enrollment. Election periods are not required for cost plan enrollment, but are necessary for disenrollment from an MA plan or PDP; therefore, this SEP provides an opportunity for MA and PDP enrollees to disenroll from their current coverage specifically to enroll in a 5-Star cost plan. Alternatively, individuals may use the 5-Star SEP to effectuate automatic disenrollment from an MA or PDP plan by submitting an enrollment into a 5-Star cost plan.

Example: A cost plan has an overall rating of 5 stars for 2020 and is open for enrollment. An individual enrolled in a MA plan uses this SEP to enroll in *the* cost plan. *The* cost plan submits the enrollment transaction to MARx using the “R” election type code, and the MA plan accepts and processes the subsequent disenrollment per the Transaction Reply Report (TRR).

Overall ratings are assigned for the plan contract year (January through December), as such, possible enrollment effective dates are the first of the month from January 1 to December 1 during the year for which the plan has been assigned an overall *performance* rating of five stars. An individual may use this SEP only one time between December 8 of the year prior to the year in which the cost plan has been granted a 5-star overall rating and November 30 of the year in which the cost plan has been granted a 5-star overall rating. The enrollment effective date is the first of the month following the month in which the plan receives the enrollment request.

Example 1: Cost Plan X has an overall rating of 4.5 stars in 2020 and 5 stars for 2021. An individual could use this SEP to request disenrollment from an MA plan for the purpose of enrolling in Cost Plan X *beginning* December 8, 2020 for an effective date of January 1, 2021. An individual could not use the SEP to disenroll from an MA plan for the purpose of enrolling in Cost Plan X for an effective date on or before December 1, 2020, as the enrollment effective dates available during that period are prior to the calendar year for which Cost Plan X has been assigned a 5-star overall rating.

Example 2: Cost Plan Y has an overall rating of 5 stars for 2020 but has lost that 5-star rating for 2021. A beneficiary could use this SEP to disenroll from an MA plan in order to enroll in Cost Plan Y for the first of the following month until November 30, 2020, with the last possible effective date available being December 1, 2020. The beneficiary could not use the SEP to disenroll from an MA plan for the purpose of enrolling in Cost Plan Y on or after December 1, 2020, as the enrollment effective dates available during that period are after the calendar year for which Cost Plan Y has been assigned a 5-star overall rating.

NOTE: Regardless of whether an individual has Part D coverage prior to use of this SEP, any individual who uses the 5-Star SEP *to disenroll from an MA plan in order* to enroll in a 5-star cost plan is eligible for a coordinating Part D SEP to enroll in either the cost plan's optional supplemental Part D benefit or in a standalone PDP. The coordinating Part D SEP applies even if the individual had stand-alone Part D coverage prior to using the 5-Star SEP to enroll in the 5-star cost plan. (See Chapter 3, Section 30.3.8 #8, letter H, of the Medicare Prescription Drug Benefit Manual for more information.)

NOTE: An individual in an MA-PD plan who chooses to use the 5-star SEP to disenroll for the purpose of enrolling in a cost plan with a 5-star overall rating would lose their prior Part D coverage. If that individual does not use the coordinating Part D SEP to obtain Part D coverage, then he or she must wait for a subsequent enrollment period to do so under the normal enrollment rules. Late enrollment penalties might also apply.

30.4 – Effect of the Duals/Low Income Subsidy (LIS) SEP on Cost Plans Offering a Part D Optional Supplemental Benefit

42 CFR 423.38

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

A dually-eligible individual or an individual eligible for the Low Income Subsidy (LIS) can only use one of the duals/LIS SEPs to enroll in a cost plan with optional supplemental Part D benefit during certain times of the year or in certain circumstances. The following SEPs permit an individual to

enroll in, disenroll from, or switch Part D plans, including a cost contract with a Part D optional supplemental benefit:

- SEP for individuals who gain, lose or have a change in their dual or LIS-eligible status (§ 30.3.8 #7 of Chapter 3 of the Medicare Prescription Drug Benefit Manual);
- SEP for CMS and State-initiated enrollments (§ 30.3.8 #15 of Chapter 3 of the Medicare Prescription Drug Benefit Manual); and
- SEP for dual- and other LIS-eligible individuals (§30.3.2 of Chapter 3 of the Medicare Prescription Drug Benefit Manual).

Individuals can use the “SEP for dual- and other LIS-eligible individuals” once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:

- January – March;
- April – June; and
- July – September

It may not be used in the 4th quarter of the year (October – December). Individuals otherwise eligible for this SEP may not use it to join or leave an optional supplemental Part D benefit while they are determined to be “potential at-risk” or “at-risk” by their Part D sponsor. However, individuals may leave the cost contract, including their optional supplemental Part D benefit, even if the cost organization has determined the individual to be “potential at-risk” or “at-risk.”

The chart below outlines the situations in which this limitation applies:

Individual currently enrolled in	Individual wants to enroll in	Allowed	If beneficiary has an active “at-risk” status
MA or Fee-for-Service (FFS) (with or without Part D)	Cost plan with optional supplemental Part D benefit	During valid Part D enrollment period	Not allowed if individual is “potential at-risk” or “at-risk” in a different Part D plan
Cost plan with optional supplemental Part D benefit	Cost plan only (staying in same cost plan and disenrolling from cost plan’s optional supplemental Part D benefit)	During a valid Part D enrollment period	Not allowed if individual is “potential at-risk” or “at-risk” in the plan’s optional supplemental Part D benefit
Cost plan with optional supplemental Part D benefit	FFS	Anytime	Allowed

40 – Enrollment Procedures

(Rev. 1, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

The enrollment form is a portion of the cost plan’s contract with the beneficiary. There are several requirements regarding the *release* of information between the plan, *Medicare* and the prospective member during the application process. There are also requirements regarding who may complete the application form.

Cost plans that offer an optional supplemental Part D benefit must ensure the required elements and language provided on the CMS Model PDP enrollment form are captured on the cost plan form. The CMS model PDP enrollment form is provided in Chapter 3 of the Medicare Prescription Drug Benefit Manual. Cost plans may add this information directly to their cost plan enrollment form(s) or use a separate additional sheet that will accompany the cost plan enrollment form. In either format, cost plans must make it clear that beneficiaries are not required to choose the cost plan’s optional supplemental Part D benefit, and therefore do not have to complete those items if not enrolling in it. Cost plans offering such a benefit must also provide information about Part D enrollment periods to potential enrollees in the cost plan’s marketing materials.

40.1 – Format of Enrollment Requests

42 CFR 417.430

(Rev. 2, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

A cost plan must accept enrollment requests it receives regardless of whether they are received in a face-to-face interview, by mail, by facsimile, or through other mechanisms as defined and allowed by CMS. Cost plans may use telephonic, online, and group enrollment mechanisms in addition to accepting paper enrollment requests. Cost plans must always have a method in place to accept paper enrollment requests. Additionally, cost plans have the option to participate in the Medicare Online Enrollment Center (OEC) on www.medicare.gov.

For paper, telephone and electronic enrollment requests, all required elements as listed in sections 40.1.1, 40.1.2 and 40.1.3, respectively, of this chapter must be included. The “Beneficiary Signature and/or Authorized Representative Signature” element for a paper request is satisfied with a pen-and-ink signature, for a telephone request it is satisfied with a verbal attestation of intent to enroll, and for an electronic request it is satisfied with an electronic signature or a clear and distinct step that requires the applicant to activate an “Enroll Now,” or “I Agree,” type of button or tool.

Electronic signatures have the same legal effect and validity as pen-and-ink signatures. A cost organization utilizing electronic signatures in electronic enrollment must, at a minimum, comply with the CMS security policies. For more information on the requirements for legally binding electronic signatures, see the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. §7001, and “Use of Electronic Signatures in Federal Organization Transactions” published by the CIO Council.

A cost plan that chooses to *offer telephonic or electronic enrollment* mechanisms cannot require beneficiaries to use *these* mechanisms and must *have, at minimum*, a paper enrollment form *available* for potential enrollees to *request* enrollment in the cost plan.

40.1.1 – Paper Enrollment Forms

42 CFR 417.430(a)

(Rev. 2, Issued: August 12, 2020; Effective/Implementation: 01-01-2021)

The cost plan must use *an* enrollment form that complies with *CMS'* guidelines on structure and content. *CMS has provided a* model enrollment form (Exhibit 1) at the end of this chapter. *Cost plans may choose to develop their own materials using the models as a guide. Materials are subject to the CMS review and approval process of plan marketing materials.* The enrollment form should include a statement acknowledging that premium and co-payment amounts may be found in the subscriber agreement or other documents, as well as *information* indicating that the enrollee *acknowledges--*

- *That they will* abide by the *rules of the* cost plan;
- *The release of* information to CMS *and other plans. Information may be used to track enrollment and for other purposes, as allowed under federal law;*
- *That* he or she may receive medical services from non-network providers, but will be liable for deductibles, coinsurance, and charges not covered by Medicare;
- *That* enrollment in the cost plan automatically disenrolls him or her from any other cost plan or Medicare Advantage plan in which he or she is enrolled; and
- *The* proposed effective date of coverage, which is the date he *or* she should begin receiving care through the plan.

The cost plan must obtain the applicant's signature and the date. If the applicant inadvertently fails to include the date of signature on the form, then the date of receipt stamped by the cost plan will serve as the signature date on the form. If an individual submits an enrollment form with a missing signature, the cost plan must follow up with the applicant and obtain a confirmation of the applicant's intention to enroll (see §40.2.2 below).

40.1.2 – Enrollment via Telephone

42 CFR 417.430(a)

(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Organizations may accept telephonic requests for enrollment into their cost plans via an incoming (in-bound) telephone call to a plan representative or agent. Organizations may also accept enrollment requests during communications initiated by the organization when, during the course of outreach to provide information about their Medicare plan offerings to individuals with whom they have an existing business relationship, the individual expresses a desire to enroll in one of the organization's plans.

Organizations that choose to offer a telephonic enrollment mechanism must follow the requirements below in addition to all other applicable program requirements:

- Enrollment requests from individuals with whom the organization does not have an existing business relationship may be accepted only during an incoming (or in-bound) telephone call from a beneficiary. This includes inbound calls to an incorrect department or extension transferred internally.
- For all telephonic enrollment requests, the cost plan must ensure that the telephonic enrollment request is effectuated entirely by the beneficiary or his or her authorized representative.

- The telephonic enrollment mechanism must clearly advise individuals that they are completing an enrollment request into the plan.
- The cost plan must record the audio of each telephonic enrollment request including a statement of the individual's agreement to be recorded, all required elements necessary to complete the enrollment (as required on the model enrollment form, Exhibit 1 in the cost plan enrollment manual), and a verbal attestation of the intent to enroll. If someone other than the beneficiary makes the request, the recording must include the attestation regarding the individual's authority under State law to complete the request, in addition to the required contact information. All telephonic enrollment recordings must be reproducible and maintained as provided in §60.4 of the cost plan enrollment manual.
- The telephonic enrollment mechanism must include a tracking mechanism (e.g., a confirmation number) to provide the individual with evidence that the cost plan received the telephonic enrollment request.
- The cost plan must provide a notice of acknowledgement and other required information as described in §40.4.1.
- The cost plan may not collect information through the telephonic enrollment mechanism that is also prohibited on the paper enrollment mechanism (e.g., impermissible health screening).
- The cost plan may not market other lines of business at any time during the enrollment call.
- Optionally, cost plans may request or collect premium payment or other payment information needed, such as a bank account number or credit card numbers, to process the form of premium payment requested by the individual.

40.1.3 – Electronic Enrollment

(Rev. 2, Issued: *August 12, 2020*; Effective/Implementation: 01-01-21)

Organizations may develop and offer electronic enrollment mechanisms made available via an electronic device or secure internet website. Plans have the option of obtaining technical and related services from outside entities in support of the cost organization's electronic enrollment mechanism, (e.g. licensed software). Organizations may use downstream entities, such as a broker or third party website, as a means of facilitating and capturing the electronic enrollment request. However, cost organizations retain complete responsibility for ensuring enrollment policies in this guidance are followed, and for ensuring the appropriate handling of any sensitive beneficiary information provided as part of the online enrollment, including those facilitated by downstream entities. From the point at which an individual selects the plan of his or her choice on the third-party website and begins the online enrollment process, CMS holds the organization responsible for the security and privacy of the information provided by the applicant and for the timely disclosure of any breaches.

Organizations that choose to offer an electronic enrollment mechanism must follow the requirements below, in addition to all other applicable program requirements:

- At a minimum, the organization's electronic enrollment mechanism must comply with CMS' data security policies.
- The cost organization must advise each individual at the beginning of the electronic enrollment process that he or she is completing an actual enrollment request to the cost plan.

- The cost organization must maintain electronic records that are securely stored and readily reproducible for the period as required in §60.4 of the cost plan enrollment manual. The organization's record of the enrollment request must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member and/or CMS. A data extract file alone is not acceptable.
- As part of the electronic enrollment process, *obtain an electronic signature from the applicant or include a clear and distinct step that requires the applicant to activate an "Enroll Now" or "I Agree" button or tool. By taking this affirmative step, the individual indicates* his or her intent to enroll. It must also be made clear to the applicant that, by taking this action, he or she agrees to the release *of information* (see the model enrollment form, Exhibit 1, for this language), and attests to the truthfulness of the data provided. The process must also remind the individual of the penalty for providing false information.
- The *electronic enrollment* mechanism must capture an accurate time and date stamp at the time the applicant activates the step in the previous bullet (i.e. "Enroll Now or I Agree" button or tool). The organization will use this data to establish the application date for the enrollment request. This time stamp also marks the start of the timeframe for processing the enrollment request, as it is at this time that the enrollment request is considered by CMS to be received by the organization.
- The electronic enrollment mechanism must inform the individual of the consequences of completing the electronic enrollment, including that the individual will be enrolled (if approved by CMS), and that he or she will receive notice (of acceptance or denial) following submission of the enrollment to CMS.
- The electronic enrollment mechanism must also indicate that if a legal representative is completing the enrollment request, he or she must attest that he or she has such authority to make the enrollment request and that proof of this authority is available upon request by CMS.
- The electronic enrollment mechanism must include a tracking mechanism to provide the individual with evidence that the enrollment request was received (e.g., a confirmation number).
- Following the acceptance of an electronic enrollment request, cost plans must provide a summary of the plan for which the individual has requested enrollment or provide a statement that the individual will receive a notice in the mail in response to the enrollment request (e.g., acknowledging receipt of the completed enrollment request or requesting additional information or denial of enrollment).
- The cost plan may not collect information on the electronic enrollment mechanism that is also prohibited on the paper enrollment mechanism (e.g., impermissible health screening).
- The cost plan may not market to or enroll beneficiaries in other lines of business or products as part of the electronic enrollment process.
- Optionally, cost plans may request or collect premium payment or other payment information needed, such as a bank account number or credit card numbers, to process the form of premium payment requested by the individual.

40.1.4 – Medicare Online Enrollment Center (OEC)

42 CFR 417.430(a)

In addition to the processes described above, cost plans, including those plans with optional supplemental Medicare prescription drug plans, may choose to participate with the OEC through the www.medicare.gov web site and the 1-800-MEDICARE Call Center. The date and time “stamped” by the OEC will serve as the application date for purposes of determining the enrollment effective date. Cost plans must promptly retrieve enrollment requests from the OEC and must check for requests at least daily.

Because the effective date for enrollment into a cost plan can vary depending on the method used by cost plans (per §30.2), the cost plan must contact the individual in order to determine his or her desired effective date. To that end, data on the cost plan’s OEC report will include a “dummy code” that will not necessarily constitute a valid enrollment effective date. Cost plans must still determine the effective date of enrollment in the cost plan’s optional supplemental Part D drug benefit separately from the cost plan enrollment itself (per §30.2.3).

CMS’ Requirements for Plans Participating in the OEC

Cost plans participating in the OEC must also meet the following requirements that apply to all plans participating in the OEC.

- With the exception of obtaining the enrollment effective date, as described above, all participating cost plans must accept enrollments received through the OEC as complete in terms of the information that the applicant is required to provide. Plans must follow up with the enrollee to get any optional information that the plan requires, but the cost plan cannot delay processing the enrollment while waiting for the additional information. Plans should refer to the cost plan enrollment guidance for a complete description of enrollment processing requirements.
- Please refer to the Medicare Online Enrollment Center File Layout document for more information on the file layout and applicable data elements for each of the OEC forms. This document is available in the “Help” section of the OEC’s Administrative Console.
- CMS expects all cost plans participating in the OEC to log into the Administrative Console ***at least once every business day*** and download any pending enrollment requests. Plans have access to information to validate the confirmation number. When necessary, they can have the enrollment re-set so that they can download the enrollment again. An organization can establish a link to the OEC directly from its web site. This option allows an organization to initiate the OEC enrollment application process but complete the OEC enrollment application on Medicare.Gov. This option is available only to those cost plans participating in the OEC. Information regarding the requirements to link to the OEC is posted in the “Help” section of the Administrative Console.

NOTE: Plans that have a link to the OEC from an external web site and decide to end participation in the OEC will be required to disable the link in order to avoid having to download enrollments from the OEC received from the external web site.

- If an enrollee has a valid online enrollment center confirmation number, the cost plan can verify the enrollment through the Administrative Console. The URL is: <https://enrollmentcenter.medicare.gov/AdministrativeConsole/PlanFinder/login.aspx>. If the

enrollment has not been downloaded, the plan should download the enrollment through its usual procedures and process the enrollment.

- If the plan is unable to find the enrollment in the Administrative Console, the plan can work via email with its designated regional office. The regional office staff can work with CMS central office to try to locate the record and validate the enrollment.

40.1.5 – Auto and Facilitated Enrollment

42 CFR 423.34

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

CMS requires that cost plan organizations offering cost plans with optional Part D supplemental benefits have a process for auto- and facilitated enrollment. Cost plans that offer a Part D optional supplemental benefit effective 2006 or later must auto or facilitate enrollment of all Part D Low Income Subsidy (LIS) eligible individuals into the plan benefit package (PBP) that includes the Part D benefit, in the same organization, if they are enrolled in the cost plan but have not elected the Part D benefit from the cost plan or another PDP, unless the individual declines the enrollment. CMS auto-enrolls and facilitates enrollment for LIS-eligible individuals into PDPs when they are enrolled in a cost plan that does not offer any Part D optional supplemental benefits whatsoever, or in an HCPP plan (as HCPP plans may not offer Part D benefits).

The auto and facilitated enrollment processes will occur monthly. As noted in the preamble to the final regulation for Part D (Federal Register Nol. 70, No. 18, January 28, 2005), the legal authority for both auto-and facilitated enrollment processes is technically termed “facilitated” enrollment, since auto-enrollment is limited to PDPs. However, the term “auto-enrollment” is used here to denote the process that applies to full-benefit dual eligible individuals, and “facilitated enrollment” to others with LIS.

CMS has safeguards in place to prevent existing full-benefit dual eligibles enrolled in a cost plan with Medicare prescription drug coverage from being auto-enrolled by CMS into a PDP. However, there may be instances in which a beneficiary election will not yet be reflected at the point in time when CMS processes auto-or facilitated PDP enrollments. In these cases, the beneficiary will receive a notice from CMS informing him/her that s/he has been enrolled into a PDP. However, once the beneficiary’s election into the cost plan with Medicare prescription drug coverage is processed by CMS, it will prevail over the previously processed auto-or facilitated PDP enrollment submitted by CMS.

Starting January 1, 2010, CMS implemented the Limited Income Newly Eligible Transition (Limited Income NET) demonstration, which modified its procedures for auto/facilitating enrollment of LIS beneficiaries into PDPs for those who have retroactive enrollment effective dates. That demonstration does not impact the auto/facilitated requirements for cost plan organizations as specified in this section.

A. Populations

1. Auto-Enrollment

Full-benefit dual eligibles in cost plans that do not include the Medicare Part D benefit will be auto-enrolled by the cost plan as described in section B below. Full-benefit dual eligible individuals are defined as those eligible for comprehensive Title XIX Medicaid benefits as well as eligible for Medicare Part D. This includes those who are eligible for comprehensive Medicaid benefits plus Medicaid payment of Medicare cost-sharing (sometimes known as QMB-plus or SLMB-plus). Please note that full-benefit dual eligible individuals do not include those eligible only for Medicaid payment of Medicare cost-sharing (i.e. QMB-only, SLMB-only, or QI).

Full-benefit dual eligible individuals to be auto-enrolled include those who are full-benefit dual eligible upon initial enrollment into a cost plan without Part D, as well as existing Medicare enrollees of a cost plan without Part D who become newly Medicaid eligible. This includes full benefit dual eligible cost plan enrollees who:

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

This excludes full-benefit dual eligibles who:

- Live in any of the five U.S. territories;
- Live in another country;
- Are individuals for whom the employer or union is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored cost plan;
- Are incarcerated, as defined in §10;
- Are not lawfully present in the U.S.;
- Have opted out of auto-enrollment into the Part D benefit; or
- Are already enrolled in a stand-alone Prescription Drug Plan (please perform a Beneficiary Eligibility Query to determine this status)

2. Facilitated Enrollment

Other LIS eligibles are defined as those deemed automatically eligible for LIS because they are QMB-only, SLMB-only, QI (i.e., only eligible for Medicaid payment of Medicare premiums and/or cost-sharing); SSI-only (Medicare and SSI, but no Medicaid); or those who apply for LIS at the Social Security Administration (SSA) or a State Medicaid Agency and are determined eligible for LIS. This includes those who apply and are determined eligible for either the full or partial level of the LIS.

Other LIS eligible individuals to be facilitated enrolled include those who are Other LIS eligible upon initial enrollment into a cost plan without Part D, as well as existing Medicare enrollees of a cost plan without Part D who become newly Other LIS eligible. This includes Other LIS eligible cost plan enrollees who:

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

This excludes Other LIS eligible individuals who:

- Live in any of the five U.S. territories,
- Live in another country,
- Are individuals for whom the employer is claiming the retiree drug subsidy, or are enrolled in an employer-sponsored cost plan without Part D,

- Are incarcerated, as defined in §10,
- Are not lawfully present in the U.S.,
- Have opted out of facilitated enrollment into the Part D benefit, or
- Are already enrolled in a stand-alone Prescription Drug Plan (please perform a Beneficiary Eligibility Query to determine this status).

B. Auto/Facilitated Enrollment Process

The procedure for auto/facilitated enrollment is as follows:

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

Auto/facilitated enrollment specifically excludes individuals in employer-sponsored cost plans without Part D, and individuals with an employer which is claiming the retiree drug subsidy. These individuals may be identified by submitting a Batch Eligibility Query (BEQ) transaction or access the BEQ information on-line.

2. The cost plan will exclude those who are already enrolled in a stand-alone PDP. The organization may submit a Batch Eligibility Query (BEQ) transaction or access the BEQ information on-line to determine whether individuals are enrolled in a stand-alone PDP.
3. The cost plan will then identify one of the following:
 - a) The cost plan PBP(s) in the same service area, and in the same organization, with the lowest combined cost plan and Part D optional supplemental premium amount. If more than one cost PBP have the same lowest premium amount, auto-enrollment must be random among the available plans. The selection of plan is without regard to the cost plan premium or cost-sharing.

Note: The beneficiary must be auto/facilitated enrolled in the lowest premium plan available, even if that plan's premiums are above the benchmark.

- b) A stand-alone Prescription Drug Plan with a basic benefit package and premium below the region-specific low-income premium subsidy amount offered by the same organization that offers the cost plan.
4. Regardless of which option it chooses, the cost plan must apply the requirement consistently to all auto/facilitated enrollees.
 5. Within 10 calendar days of identifying an individual as needing auto/facilitated enrollment, the cost plan sends an auto/facilitated enrollment notice to the beneficiary (see Exhibits 13, 13a, 14, and 14 a.).
 6. Submit a 61 transaction (PBP change enrollment transaction) for the auto/facilitated enrollment into the cost plan PBP that includes the optional supplemental Part D benefit and

include the appropriate effective date within the timelines specified below (see subsection C). The cost plan will be notified of the accepted enrollment via a transaction reply:

- a) Auto-enrollment – within 10 calendar days of sending notice
- b) Facilitated enrollment – by last day before effective date of facilitated enrollment.

C. Effective Date of Auto/Facilitated Enrollments

1. Auto-Enrollment

The effective date of auto-enrollment is retroactive to the first day of the month the individual first became a full-benefit dual eligible or January 1, 2006, whichever is later. For individuals who are full-benefit dual eligible upon enrollment into a cost plan without part D, the effective date would be retroactive to the effective date of enrollment in the cost plan. For existing Medicare enrollees of a cost plan without part D who subsequently become Medicaid eligible, the effective date is retroactive to the first day of the month the person became Medicaid eligible. In no case will the effective date of auto-enrollment precede the date that the individual became an enrollee of the cost plan.

There is nothing that prohibits a full-benefit dual eligible from initially electing a cost plan without Part D. To ensure they understand the consequences of doing so, marketing material and the acknowledgement letter must emphasize that prescription drugs are not covered.

2. Facilitated Enrollment

The effective date of facilitated enrollment for all Other LIS eligible members is the first day of the second month after the person is identified as qualifying for facilitated enrollment. For example, if the plan is notified in August 2010 that an existing member of a cost plan without Part D has become LIS eligible, the effective date of facilitated enrollment into the PBP that includes the optional supplemental Part D benefit is October 1, 2010.

The cost plan may move up the effective date of a facilitated enrollment by one month if an Other LIS beneficiary requests this in a timely fashion, i.e., before the start of earlier month. The SEP that permits the individual's enrollment in the optional supplemental Part D benefit under section 30.3.8 #7 in Chapter 3 of the Medicare Prescription Drug Benefit Manual should be used.

Example: The cost plan facilitates enrollment of an Other LIS eligible in May, 2010, effective July 1, 2010. The beneficiary receives the facilitated enrollment by the last day in May, and requests that the cost plan makes the facilitated enrollment effective June 1. The cost plan submits an enrollment transaction (code 61) to do so.

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

Cost plans need to distinguish full benefit dual eligibles from others with LIS for purposes of setting the effective date. The first step is to identify all LIS eligibles in the cost plan PBP(s) that do not include the optional supplemental Part D benefit, e.g. through the LIS bi-weekly report. Please be sure to exclude those who are already enrolled in a stand-alone Prescription Drug Plan. CMS does not transmit a data element to plans that can be used to distinguish full-benefit dual eligibles from other LIS. As a result, CMS sends a monthly “Auto Assignment Full Dual Notification File” (for file

format and technical specifications, please see F.24 of the Plan Communications User Guide, on the CMS website at <http://www.cms.hhs.gov/mmahelp>). This file identifies full-benefit dual eligibles.

Use the Auto Assignment Full Dual Notification File to identify the subset of the LIS enrollees in the cost plan without the Part D benefit who are full-benefit dual eligibles. To determine the auto-enrollment effective date, identify the enrollment start date in the field of the Transaction Reply Report where a TRC 121 is sent.

The remaining LIS eligibles in the cost plan without the Part D benefit qualify for facilitated enrollment, and the effective date should be set as noted in item 2 above.

D. Notice

The cost plan will notify the beneficiary in writing that she or he will be auto or facilitated enrolled on the specified effective date. The notice must be sent within 10 calendar days of identifying the individual as qualifying for auto/facilitated enrollment. The notice will inform the beneficiary that they may choose another Part D plan or opt out of auto/facilitated enrollment into the Part D benefit. If the beneficiary does not opt out, or choose another Part D plan within the specified deadline, the person's silence will be deemed consent with the auto/facilitated enrollment, and it will take effect on the effective date. These individuals will also be informed they have Special Enrollment Period (SEP) options that permit them to change Part D plans, even after the auto/facilitated enrollment takes effect. There is an SEP which permits one opportunity to make an election within three months of the effective date of the assignment, or notification of the assignment, whichever is later. See § 30.3.8 of Chapter 3 of the Medicare Prescription Drug Benefit Manual for more information. In addition, dual-eligible and LIS-eligible individuals have a separate SEP to make an enrollment change, as outlined in § 30.4.

1. Auto-Enrollment

Please use the appropriate model notice language, as follows:

- Exhibit 13 (auto-enroll into cost plan with Part D)
- Exhibit 13a (auto-enroll into PDP)

The deadline for responding is 10 calendar days from when the notice is sent.

2. Facilitated Enrollment

Please use the model notice language, as follows:

- Exhibit 14 (facilitated enrollment into cost plan with Part D)
- Exhibit 14a (facilitated enrollment into PDP)

The deadline for responding is the last day before the facilitated enrollment effective date.

E. Opt-Out

Full-benefit dual eligible and Other LIS individuals may opt-out, or affirmatively decline, the Part D benefit. Beneficiaries may opt-out verbally or in writing. For a cost plan enrollee, this primarily means declining auto/facilitated enrollment and maintaining enrollment in the cost plan (without part D). The cost plan may check the common User Interface to see if the individual has previously opted

out; if so, the person should not be auto/facilitated enrolled. Once a beneficiary has opted out, the cost plan should document this and not include them in future auto-enroll processing.

The cost plan should counsel the individual to ensure they understand the implications of their request to decline, and should confirm this in writing (see Exhibit 15) within 10 calendar days of the individual's request to opt out. If a beneficiary opts out of auto/facilitated enrollment by the deadline in the auto/facilitated notice, do not submit an enrollment transaction that would move them to a cost plan PBP that includes the optional supplemental Part D benefit. This will have the effect of leaving them in the cost plan without Part D.

If the individual opts-out after the cost plan has submitted the code 61 transaction, the effective date of returning to the cost plan without the Part D benefit is normally prospective, i.e., first day of the following month. However, through the end of the month after notice was sent, at the beneficiary's request, the cost plan may restore the person to the cost plan without the Part D benefit retroactive to the auto-enrollment effective date. This is accomplished by submitting a code 61 transaction with the same effective date, and setting the opt-out flag as noted below.

LIS eligible individuals who want to opt-out of auto/facilitated enrollment must do so with the cost plan, not through 1-800-MEDICARE. This differs from the procedure for LIS eligible individuals full duals who want to opt-out of auto-enrollment into a stand-alone PDP. The cost plan sends a code 61 transaction (to move the person back to the cost plan PBP without the optional Part D benefit), setting the Part D Opt-Out Flag (field 38) to Y (opt-out of auto-enrollment).

An LIS eligible individual who opts out does not permanently surrender his or her eligibility for, or right to enroll in, a Part D plan; rather, this step ensures the person is not included in future monthly auto-enrollment processes. To obtain Part D benefits, the beneficiary simply makes a voluntary election into a plan that offers Part D benefits.

F. Special Procedures for Individuals With Employer Coverage with a Retiree Drug Subsidy

When the individual's employer or union-sponsored enrollment, including in "800 series" plans, or Retirement Drug Subsidy (RDS) status is known, the cost plan shall exclude the individual from auto/facilitated enrollment.

It is possible the cost plan will not be aware an individual has RDS until they submit a code 61 transaction to auto/facilitate his or her enrollment. As with all enrollment transactions for individuals with RDS, MARx will enforce a two-step process, initially rejecting the transaction. The cost plan must follow normal procedures of confirming with the beneficiary that she/he wants to be enrolled in the Part D benefit and, if confirmed, resubmit the transaction with the employer subsidy override.

G. Information Provided to Auto/facilitated Enrolled Beneficiaries

The cost plan must send a modified version of the pre-and post-enrollment materials required to be provided to all new enrollees. If the effective date is retroactive into the previous calendar year, only send the current year's version of the documents below.

Prior to effective date, the cost plan must send:

- The information required in §40A.1, and
- A Summary of Benefits (those who are auto/facilitated enrolled still need to make a decision whether to stay with the plan into which they have been auto/facilitated enrolled or change to another one that better meets their needs). Providing the Summary of Benefits, which is considered marketing material normally provided prior to making an enrollment election, ensures that those auto/facilitated enrolled have a similar scope of information as those who voluntarily enroll.

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

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
Frequency	Monthly	Monthly
Steps	<ul style="list-style-type: none"> • Identify full dual eligibles in cost plan who need to be enrolled into cost plan PBP that includes Part D benefit • Send notice to beneficiary within 10 calendar days of identifying need for person to be auto-enrolled • If no answer or person does not opt out within 10 calendar days, submit 61 transaction to move to the cost plan PBP that includes the Part D benefit 	<ul style="list-style-type: none"> • Identify non-full dual LIS beneficiaries in cost plan who need to be enrolled into the cost plan PBP that includes the Part D benefit • Send notice to beneficiary within 10 calendar days of identifying need for person to be facilitated enrolled • If no answer or person does not opt out by last day before effective date of facilitated enrollment, submit 61 transaction to move to the cost plan PBP that includes the Part D benefit
Who needs to be moved	<ul style="list-style-type: none"> • Full dual who newly enrolls in the cost plan without the Part D benefit • Beneficiary in the cost plan without the Part D benefit who recently became Medicaid eligible and is thus newly full dual 	<ul style="list-style-type: none"> • Non-full dual with LIS who newly enrolls into the cost plan without the Part D benefit • Beneficiary in the cost plan without the Part D benefit who recently became LIS-eligible
Who does not need to be moved	<ul style="list-style-type: none"> • Those who have already opted out • Those with RDS or employer coverage who do not consent to auto-enrollment 	<ul style="list-style-type: none"> • Those who have already opted out • Those with RDS • Those in employer sponsored plans
Data to identify those in cost-only plan who need to be moved to cost-PD plan	Full dual Auto Assignment notification file	LIS data (<i>DTRR</i> or monthly LIS history report): <ul style="list-style-type: none"> • Premium subsidy = 25%. 50%, 75% OR <ul style="list-style-type: none"> • Premium subsidy = 100 and LIS copay = 4 (15%) • Premium subsidy = 100 and LIS copay = 1, 2 or 3 and person is

	Auto-Enrollment of Full Duals	Facilitated Enrollment of Other LIS
		not on Full dual Auto Assignment notification file
Plan Into Which Beneficiary Should be Enrolled	Cost plan PBP that includes the Part D benefit with the lowest combined cost plan and Part D premium, or PDP	Cost plan PBP that includes the Part D benefit with the lowest combined cost plan and Part D premium, or PDP
Notice to send	Exhibit 13 or 13a	Exhibit 14 or 14a
Effective date	<ul style="list-style-type: none"> • First day of the month person qualified for LIS (will be retroactive) • Cannot be prior to start of enrollment in the cost plan 	<ul style="list-style-type: none"> • First day of second month after person identified as needing enrollment • Cannot be prior to start of enrollment in the cost plan
Opt out	<ul style="list-style-type: none"> • Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 15) • If submitting 61 transaction to move beneficiary back to cost plan PBP that does not include Part D benefit, set Opt-Out flag to Y (field 38) 	<ul style="list-style-type: none"> • Document and do not enroll again in future. • Confirm with beneficiary (see Exhibit 15) • If submitting 61 transaction to move beneficiary back to cost plan PBP that does not include Part D benefit, set Opt-Out flag to Y (field 38)
Application date on transaction	First day of month prior to effective date of the enrollment OR day after current application date on the cost plan PBP that does not include the Part D benefit, whichever is later.	First day of month prior to effective date of the enrollment.
Election type code	Z = Special Enrollment Period*	S = Special Enrollment Period
Enrollment source code	E (MA/cost plan submitted auto-enrollment)*	F (MA/cost plan submitted facilitated enrollment)*

* Use of the enrollment period of “Z” and enrollment source code of “E” permits these 61 transactions for retroactive auto-enrollments to bypass normal MARx suspension of processing for retroactive effective dates (i.e. they will process immediately).

40.1.6 – Group Enrollment Request Mechanism for Employer/Union Sponsored Coverage

42 CFR 417.430(a)

Cost plans may choose to accept voluntary enrollment requests directly from the employer or union who sponsors cost plan coverage for its members in any of the enrollment mechanisms described in this guidance (except auto or facilitated enrollment).

It is the cost organization’s responsibility to ensure that all applicable enrollment requirements are met as required by CMS. The enrollment requests provided to the cost plan by the employer or union will reflect the choice of retiree coverage individuals made using their employer’s or union’s process for selecting a health plan. For enrollments processed using an employer/union sponsored

mechanism, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of enrollment into the employer or union group-sponsored cost plan. For the purposes of providing notices and meeting other timeframe requirements provided in this guidance, use the date the cost plan received the request.

CMS will allow a cost plan to accept enrollment requests using a group enrollment process in which beneficiaries enroll in an employer or union sponsored cost plan. Beneficiaries participate in this process through advance notification that provides each individual with all the information necessary to make an informed choice. Furthermore, the process must provide CMS with any information the employer/union has on other insurance coverage for the purposes of coordination of benefits. It is the cost plan's responsibility to ensure the group enrollment process meets all applicable cost plan enrollment requirements. **Cost plans must ensure that any contracts and other arrangements and agreements with employers and unions intending to use the group enrollment process make these requirements clear.**

The group enrollment process *must* provide the following information to each beneficiary:

- Beneficiaries participate in the group enrollment mechanism by receiving an advance notice that the employer/union intends to enroll them for a prospective coverage effective date in a cost plan that the employer/union is sponsoring;
- Clear instruction that the beneficiary may affirmatively opt out of such enrollment; explaining the process to opt-out; and any consequences to employer or union benefits opting out would bring;
- This notice must be provided by the cost plan, or the employer or union acting on its behalf (as specified in the contract the cost plan has with the employer/union), not less than 21 calendar days prior to the effective date of the beneficiary's enrollment in the employer/union sponsored cost plan;
- The information provided to each beneficiary must include a Summary of Benefits offered under the employer/union sponsored cost plan, an explanation of how to get more information about the cost plan, and an explanation on how to contact Medicare for information on other Medicare health plan options that might be available to the beneficiary; and
- Each individual must also receive in the group enrollment notice materials the enrollment agreement and release of information contained in Exhibit 1 under the heading "Please Read & Sign Below."

The cost plan must ensure all of the above requirements are met prior to submission of the enrollment transactions to CMS. For enrollments processed using a group enrollment mechanism, the application date on the enrollment transaction submitted to CMS is the first day of the month prior to the effective date of the group enrollment. This will ensure that any subsequent beneficiary-generated enrollment request will supersede the group enrollment in CMS systems.

The employer or union must provide in the group enrollment file(s) all the information required for the cost plan to submit a complete enrollment request transaction to CMS, including permanent residence information. Records must be maintained as outlined in §60.4 of this chapter.

40.2 – Verifying Enrollment Information

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

If an individual completes an enrollment request during a face-to-face interview, the cost organization may ask to see the individual's Medicare card to verify the spelling of the name, and to confirm the correct recording of Medicare Number, and entitlement dates for Medicare Part A and/or Part B. The individual does not have to show or provide the Medicare card or other evidence when submitting the request. Other forms of evidence *as described in the bulleted list below* are only requested when the enrollment request doesn't include the Medicare Number and the plan is unable to locate the individual in CMS systems.

Following the procedures outlined in the CMS Plan Communications User Guide (*PCUG*), Cost organizations must verify Medicare entitlement using the Batch Eligibility Query (BEQ) process or MARx online query (M232 screen) for all enrollment requests. CMS systems are updated within two business days of SSA processing new or changed Part A or Part B entitlement for a Medicare beneficiary. The CMS systems are the most up-to-date data regarding Medicare entitlement for the beneficiary. Individuals are not required to provide evidence of entitlement to Medicare Part A and/or enrollment in Part B with the enrollment request.

The Medicare Number will be assigned at the time CMS first receives entitlement information for a new beneficiary. In the event that the enrollment request doesn't include the Medicare Number and the plan is unable to locate the individual in the BEQ or MARx online query, the organization should consider the enrollment request incomplete and follow § 40.2.2.

The individual may provide the Medicare Number to the organization verbally or in writing. Examples of documents the beneficiary may send to the plan which display the Medicare Number (and entitlement information) include:

- Medicare card;
- Medicare Award notice from SSA (shows Medicare entitlement dates only);
- Benefit Verification notice from SSA (includes Medicare Number and entitlement start dates);
- Medicare card information from the individual's MyMedicare.gov account; and
- A notice from CMS regarding change in Medicare Number.

NOTE: If the beneficiary provides any of the notices listed above, the date on the letter should be no more than two months before the enrollment request was received by the organization. If there is a discrepancy between the entitlement information in a document and the information in CMS' systems, use the data in CMS systems to determine eligibility for enrollment.

The plan must obtain the applicant's permanent residence address and verify that he or she resides within the service contract area. If enrollment assistance is given by telephone, a back-up system should be established for verifying this information. For example, some cost plans direct staff responsible for recording enrollment information to call the applicant and double-check the information. The plan must also verify U.S. citizenship or lawful presence status via CMS systems to determine eligibility for enrollment.

Cost plans offering an optional supplemental Part D benefit must use the BEQ (batch process or on-line inquiry), as described in the Plan Communications User Guide, for individuals electing the cost plan's optional supplemental Part D benefit as permitted in this Chapter to verify eligibility for Part D and obtain important information about Low Income Subsidy status.

U.S. Citizenship or Lawful Presence Information

Cost organizations must use the CMS Batch Eligibility Query (BEQ), (individual or batch submission) or via on-line access, the MARx M232 screen, to verify eligibility on the basis of incarceration status or unlawful presence status. An exception to this are enrollment requests from a current enrollee of a cost plan who is requesting enrollment into another cost plan offered by the same parent organization with no break in coverage (i.e., "switching plans").

Individuals are not required to provide evidence of U.S. citizenship or lawful presence status with the enrollment request, nor are cost organizations permitted to request such information or documentation. The systems (BEQ or MARx online query) will indicate the lawful presence status of a non-U.S. citizen, including the start and, if applicable, the end date of the unlawful presence status of the individual.

CMS eligibility queries will only reflect data for the existence of an unlawful presence status. When neither the BEQ nor the MARx online query shows any indication of unlawful presence in the U.S., the cost organization must treat the lack of information as confirmation of evidence of U.S. citizenship or lawful presence status.

When either the BEQ or the MARx online query shows an indication of unlawful presence in the U.S. and the organization receives documentation of lawful presence from the applicant, the plan cannot use this documentation to establish eligibility. If the cost organization is provided evidence of lawful presence by the applicant in the form of a document from the Department of Homeland Security or SSA and neither the BEQ nor the MARx online query reflects this lawful presence status, the organization should refer the applicant to SSA to request that SSA update its records.

40.2.1 – Who May Complete a Cost Plan Enrollment or Disenrollment Request

A Medicare beneficiary is generally the only person who may execute a valid request for enrollment in or disenrollment from a cost plan. However, another individual could be the legal representative or appropriate party to execute the cost plan enrollment or disenrollment as the law of the State in which the beneficiary resides may allow. CMS will recognize State laws that authorize persons to take such actions on behalf of a Medicare beneficiary. For example, persons authorized under State law may be court appointed legal guardians, persons having durable power of attorney for health care decisions or individuals authorized to make health care decisions under State surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity.

If a Medicare beneficiary is unable to sign an enrollment form or disenrollment request or is unable to complete an enrollment request mechanism due to reasons such as physical limitations or illiteracy, State law would again govern whether another individual may execute the enrollment/disenrollment request on behalf of the beneficiary. Usually, a court-appointed guardian is authorized to act on the beneficiary's behalf. If there is uncertainty regarding whether another person may sign for a

beneficiary, cost plan organizations should check State laws regarding the authority of persons to sign for and make health care treatment decisions for other persons.

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

When someone other than the Medicare beneficiary completes an enrollment form (or disenrollment request), he or she must attest to having the authority under State law to do so and confirm that authorization, if any, required by State law that empowers the individual to effect an election on behalf of the applicant is available and can be provided upon request to CMS. The individual acting on behalf of the Medicare beneficiary must also provide contact information to the cost plan. The cost plan must retain the record of this attestation, including the contact information, as part of the enrollment form. The CMS model enrollment form for cost plans (see Exhibit # 1 of this chapter) includes a sample attestation. Cost plans may not require individuals to provide documentation as a condition of accepting the enrollment or disenrollment request.

If anyone has reason to believe that an individual making an election on behalf of a beneficiary may not be authorized under State law to do so, the cost plan should contact its CMS account manager with all applicable documentation regarding State Law and the case in question. The account manager may request supporting documentation from the individual making the election.

If the cost plan receives an enrollment form that was signed more than 30 calendar days prior to the organization's receipt of the form, the plan is encouraged to contact the individual to confirm intent to enroll prior to processing the enrollment, and to advise the beneficiary of the upcoming effective date.

40.2.2 – When the Enrollment Form Has Missing or Erroneous Information (Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

To obtain information to complete the enrollment request, the cost plan must contact the individual to request the information within ten calendar days of receipt of the enrollment request. When the cost plan receives an enrollment request that cannot be processed because it has missing (or erroneous) information (including the enrollee's signature or the signature of the enrollee's representative for paper enrollment requests), it should contact the individual by telephone to obtain the information necessary, and document all efforts to obtain the information needed. In the case of a missing signature, the cost plan must obtain and document verbal confirmation of the beneficiary's intent to enroll. If the request is missing the Medicare Number, see §40.2 for more information.

The cost plan may also send a letter asking for information to facilitate the enrollment (see Exhibit 3). The cost plan must explain to the individual that he or she has 30 calendar days in which to submit the additional information or the enrollment will be denied. If the individual does not respond within 30 days of the request for additional information, the cost plan must deny the enrollment, and must send the appropriate notice to the individual (Exhibit 5) within the 7 business days following this denial.

If the cost plan receives all documentation within allowable time frames, and the enrollment request is complete, the cost plan must transmit the enrollment to CMS within the time frames prescribed in §40.4, and must send the individual the information described in §40.4.1.

40.3 – ESRD and Enrollment

Please refer to §20.2 of this chapter for information on when a beneficiary with ESRD may be eligible to enroll in a cost plan.

If a cost plan is aware that an individual electing a plan has received a kidney transplant (e.g., the individual informs the cost plan this has occurred), then the plan should request that the individual submit medical documentation that he or she no longer has ESRD (i.e., a letter from the physician that states the individual has received a kidney transplant and no longer requires a regular course of dialysis to maintain life). Upon receipt of this documentation, the cost plan should enroll the beneficiary.

If an individual indicates on the enrollment form that he or she does not have ESRD but the cost plan receives a reply listing containing a “code 45” (an explanation of reply listing codes is contained in Plan Communication User Guide (PCUG)), the cost plan should investigate further to determine whether the individual is eligible to enroll. To determine eligibility, the cost plan should contact the individual and request medical documentation. Contact can be made orally, in which case the cost plan must document the contact and retain the documentation in its records.

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

1. Evidence of contact with the individual after the system rejection, including the individual’s explanation for rejection for example, a successful transplant, and medical documentation, i.e., a letter from the physician that documents that the individual has received a transplant that has restored kidney function.
2. A copy of the Reply Listing or, if using the services of a CMS subcontractor, a report indicating the cost plan's attempts to enroll the individual and the resulting rejection.

Once received and approved, the Regional Office will override the enrollment rejection for the individual.

40.4 – Processing Applications

(Rev. 1, Issued: 06-15-17; Effective/Implementation: 01-01-18)

The cost plan must maintain a system for receiving, controlling and processing applications for membership in which it:

- Date-stamps each application with the date the form was received;

- Ensures that each beneficiary who enrolls (whether previously a member of the organization or not) receives an identifier (e.g., a tracking number) for a request made through a non-paper enrollment mechanism;
- Processes applications from beneficiaries in chronological order by received date;
- Contacts the beneficiary if additional information is needed to process the enrollment (see Exhibit 3 and additional information in §40.2.2).
- Notifies the beneficiary in writing of the cost plan's acceptance or denial of his /her application no later than 30 calendar days following the date the application was received;
- If the application is accepted, the plan must inform the beneficiary of the proposed effective date of coverage (see Exhibit 2);
- If the application is denied, the plan must provide the applicant with a written explanation of the reason for denial (see Exhibit 5 and additional detail in §40.5 of this chapter)

For Cost Plans that have obtained a capacity waiver:

- Places the application on a waiting list as described in §30.1.5 of this chapter, and provides the beneficiary with an explanation of procedures to follow as vacancies occur, and
- Fills vacancies occurring during an enrollment period in chronological order, beginning with the earliest dated application on the list.

Once the plan receives a reply listing report from CMS indicating whether the individual's enrollment has been accepted or rejected, the plan must send written notification to the beneficiary that CMS accepted or rejected his or her enrollment application (see Exhibit 4 and Exhibit 5).

40.4.1 – Information Provided to the Beneficiary

(Rev. 2, Issued: *August 12, 2020*; Effective/Implementation: 01-01-21)

During the enrollment process, the cost plan must provide the enrollee with all the necessary information about being a member of the cost plan, including the plan rules and the member's rights and responsibilities. The cost plan must ensure that the enrollee is provided with the following:

- A description of the charges for which the beneficiary is liable, e.g. any premiums, coinsurances, fees, or other amounts. For a high option, amounts attributable to the Medicare deductible and coinsurance should be explained in detail.
- An explanation of the beneficiary's *acknowledgement of the release* of information between the cost plan and CMS *and how that information may be used, as allowed under Federal law* (that is generally included on the application form).
- A letter acknowledging receipt of the completed enrollment request and showing the effective date of coverage (see Exhibit 2). For cost plans that offer an optional supplemental Part D benefit, this notice must include all the information necessary for the individual to obtain pharmacy coverage as of the 1st day of enrollment (commonly referred to as “4 Rx” data).
- Following receipt of the confirmation of enrollment from CMS, notify the enrollee in writing (see Exhibit 4) of the effective date of enrollment within 30 calendar days and send a CMS-approved evidence of coverage that describes the cost plan organization rules, including benefits and enrollee rights and responsibilities (42 CFR 417.436).

40.5 – Cost Plan Denial of Enrollment

42 CFR 417.424

A cost plan must deny an enrollment based on its own determination of the ineligibility of the individual to enroll in the plan. A Medicare cost organization may also deny enrollment to an individual who meets the criteria of §20, if acceptance would:

- Cause the number of enrollees who have both Medicare and Medicaid to exceed 50% of the cost plan's total enrollment.
- Prevent the Medicare cost organization from complying with their contract with CMS.
- Require the Medicare cost organization to exceed its enrollment capacity
- Cause the enrollment to become substantially non-representative of the general population in the Medicare cost plan's geographic area.
 - Disenrollment for non-representative of the general population requires CMS approval.

Cost plan denials occur before the organization has transmitted the enrollment to CMS. For example, it may be obvious that the individual is not eligible to elect the plan due to inc residence, or that the cost plan is closed for enrollment, etc. This up-front denial determination must be made in a timely manner, within 30 calendar days from the date the organization received the enrollment form.

Notice Requirement - The organization must send written notice of the denial to the individual that includes an explanation of the reason for denial (Exhibit 5). The cost plan must send this notice no later than 30 calendar days from the date the organization received the enrollment form.

If the cost plan is following the procedures in §40.2.2 of this chapter to request additional information from a beneficiary, the denial notice should be sent within 7 business days of the denial determination made when the request for additional information period expires.

40.5.1 – Cost Plan Denial of Enrollment in Optional Supplemental Part D Benefit

As described in §10.2 of this chapter, new and existing cost plan enrollees may only enroll in an optional supplemental Part D benefit offered by the cost plan in accordance with the Part D Enrollment requirements including Part D enrollment periods.

If an individual who is eligible to enroll in a cost plan (or who is an enrollee of that plan) requests enrollment in the cost plan's optional supplemental Part D benefit at a time when enrollment in Part D is not permitted, the cost plan must provide the individual with written notice that he or she may only enroll in the Part D optional supplemental benefit at specified times and cannot enroll in it at this time. This notice must be provided within 10 calendar days of the receipt of the request to select the optional supplemental benefit. Refer to Exhibit 5a for a model notice.

40.6 – Transmission of Enrollments to CMS

42 CFR 417.432(e)

Within 30 days of the date of the organization's receipt of the completed enrollment form, the cost plan must transmit information necessary to add the beneficiary to CMS records. In the case of applications that are accepted when the cost plan enrollment is at a capacity limit, it must transmit the information by the earliest plan data due date after a vacancy has become available. However, if a current commercial plan member is converting to Medicare enrollment status, the plan must submit the enrollment information no earlier than the third plan data due date, but no later than the first plan data due date, prior to the individual's Medicare entitlement date. Cost plans are strongly encouraged to submit all enrollment requests to CMS within 7 calendar days. If the cost plan enrollment transaction includes the enrollment into an optional supplemental Part D benefit, the cost plan **must** meet this time frame.

40.7 – Re-enrollment

If the Medicare cost organization requires periodic re-enrollment, it must re-enroll Medicare enrollees unless they meet the disenrollment requirements found in §§ 50.2 or 50.3.

50 – Disenrollments

42 CFR 417.460

Cost plans must submit disenrollments to CMS no later than the systems cut-off date of the month for which disenrollment is requested. Disenrollment requests can be submitted up to 90 days prospectively. Except as provided for in this section a cost plan may not, either orally or in writing or by any action or inaction, request or encourage a member to disenroll from the plan. Cost plans are strongly encouraged to submit disenrollment requests to CMS within 7 calendar days. If the cost plan the individual is disenrolling from includes an optional supplemental Part D benefit, the cost plan **must** meet this timeframe.

50.1 – Voluntary Disenrollments

A Medicare beneficiary may disenroll at any time by mailing, hand delivering, or faxing a signed and dated written notice to the plan. If the member is unable to sign the disenrollment request, his or her legal representative must do so (refer to §40.2.1 for more details on who may sign forms). CMS systems will generate an automatic disenrollment if a beneficiary elects another cost plan or Medicare Advantage plan without first disenrolling from the current health plan. Note: Enrollment into a Medicare Advantage plan may only be requested by an individual during the enrollment periods applicable to that program.

If a cost plan receives a written disenrollment request without a valid signature, the cost plan may verify with the individual or legal representative with a phone call rather than returning the written request as incomplete, provided the contact is documented and retained.

If a member verbally requests disenrollment from the cost plan, the plan must instruct him or her to make the request in writing. The plan may send a disenrollment form to the member upon request (see Exhibits 6 and Exhibit 6a).

The liability of CMS to make monthly payments on the beneficiary's behalf ends with the close of the last month of membership specified by the beneficiary, with the exception that the last month of payment may not be earlier than the month in which the beneficiary requested disenrollment. However, if the Regional Office has reason to review the disenrollment request, the last month of CMS liability may not follow this guideline, e.g. if the member moved out of the service area and the Regional Office grants an earlier disenrollment date.

Individuals enrolled in a cost plan and an optional supplemental Part D benefit offered by that cost plan, are disenrolled from both upon disenrollment from the cost plan.

When an individual who is enrolled in a cost plan and an optional supplemental Part D benefit offered by that cost plan successfully enrolls in a stand-alone PDP, he or she must be disenrolled from the optional supplemental Part D benefit offered by the cost plan.

50.1.1 – Effective Date of Voluntary Disenrollment

The disenrollment must be effective no later than the first day of the month following receipt of the member's written request for disenrollment, unless the member requests a later date. The plan must

date stamp the disenrollment request upon initial receipt. If the member requests a later effective date, it can be no later than the third month after the month in which CMS receives an acceptable disenrollment request from the cost plan.

The cost plan must provide the member with a copy of his or her request for termination of enrollment (Exhibit 7 may be used if desired). CMS encourages cost plans to provide the beneficiary with a final letter once the disenrollment has been confirmed and should send this notice within 7 business days of the availability of the reply listing (Exhibit 8).

If the plan learns of the disenrollment through the CMS Reply Listing Report rather than by written request, the cost plan is strongly encouraged to provide the beneficiary with a final letter within 7 business days of the availability of the reply listing (see Exhibits 8 and 8a).

50.1.2 – Group Disenrollment for Employer/Union Sponsored Cost Plans

CMS is providing a process for group disenrollment from an employer or union sponsored cost plan. CMS will allow an employer or union to disenroll its retirees from an employer or union sponsored cost plan using a group disenrollment process.

The group disenrollment process must include notification to each beneficiary involved that the employer or union intends to disenroll them from the cost plan that the employer or union is offering. This notice should be provided not less than 21 calendar days prior to the effective date of the beneficiaries' disenrollment from the employer/union sponsored cost plan.

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

The employer/union must have and provide all the information required for the cost plan to submit a complete disenrollment request transaction to CMS, as described in this guidance. Records must be maintained as outlined in §60.4 of this chapter.

50.2 – Required Involuntary Disenrollments

The cost plan must disenroll a member from the plan in the following cases:

- A permanent change in residence (includes incarceration) out of the plan's geographic service area (§50.2.1), or a temporary absence from the plan's service area for more than 90 consecutive days (except as described in §50.2.1.1);
- Death of the member (§50.2.2);
- Member's loss of entitlement to Medicare Part B (§50.2.3);
- Termination or non-renewal of the cost plan's contract (§50.2.4); and
- The member is not lawfully present in the United States (§50.2.6).

50.2.1 – Permanent Move Out of the Plan’s Service Area

A beneficiary must be disenrolled if he or she permanently moves out of the plan’s geographic service area and does not voluntarily disenroll. The plan must initiate disenrollment as soon as it becomes aware that the beneficiary has permanently moved outside the service area. An uninterrupted absence of more than 90 days is deemed to be a permanent move (see the exception in §50.2.1.1). A written statement from the beneficiary or other reasonable evidence establishes that the beneficiary has moved out of the service area. Even if the beneficiary has not informed the plan of his or her new address, the plan must provide notification of disenrollment to the beneficiary. CMS encourages the plan to send final confirmation of disenrollment to the member.

In the case of incarcerated individuals, CMS will involuntarily disenroll individuals who are incarcerated based data CMS receives from SSA. CMS will report the disenrollments to the organization via the daily *DTRR* using a specific Transaction Reply Code (TRC). For all such disenrollments, the effective date of disenrollment will be the first of the month after the incarceration start date.

Cost organizations may receive notification of an individual’s possible incarceration status via another source. In this situation, the cost organization needs to investigate and, following current processes, determine if the member resides in the plan’s geographic service area and, if appropriate, involuntarily disenroll the member. If the incarceration information is received from a public entity or other source with direct access to confirmed incarceration data, such as a penal facility, state Medicaid agency or other state or federal agency, additional investigation is not necessary. Disenrollment is effective the first of the month following the organization’s confirmation of a current incarceration. The cost organization is required to send notification of the disenrollment to the member.

50.2.1.1 – Retention of Members Who Temporarily Leave the Plan’s Service Area

Cost plans are allowed to retain a Medicare member under either of the two options described below if the member leaves the plan’s service area for an extended absence. An extended absence is one that is over 90 days, but not more than 1 year, and where the member intends to return to the service area within the 1 year period. The extended absence option is available only to members remaining in the United States.

Option 1 -General Retention Option

The cost plan may choose to cover all out-of-area routine services for anyone who leaves the service area for an extended absence. If the plan offers such a service, it must advise all members of its availability. When an individual who has taken advantage of this policy returns to the service area, he or she must resume obtaining medical services through network providers in order for services to be covered in full. However, the member can still elect to obtain services from non-network providers, but he or she will be responsible for any applicable Medicare coinsurance and deductibles. If the member elects to obtain care from non-network providers, those providers can submit bills to Original Medicare for payment consideration.

The cost plan may place restrictions on the services received out-of-area for individuals who take advantage of the extended absence option, as long as the Medicare beneficiary agrees to the

restrictions and the full scope of contracted benefits is available to the member in the extended service area. Possible restrictions on services include obtaining medical care through designated providers or requiring prior authorization. Non-designated providers or those seen without prior authorization (where required) would submit bills to Original Medicare.

Additionally, the cost plan remains financially liable for emergency and out-of-area urgently needed services.

Option 2 -Retention of Enrollment With Services Provided Through Affiliated Organization

If the cost plan is affiliated with another organization (by common ownership or control, or written agreement), the plan may make the extended absence option available only to members who move to the affiliate's service area during an extended absence. The members must agree to obtain services exclusively through the affiliated organization. The cost plan may retain such individuals as Medicare members of its plan for up to one year. This option must be made available to anyone moving to the affiliated organization's service area during an extended absence, and all plan members must be advised of the availability of this service.

Also, the cost plan is financially responsible for emergency and out of area urgently needed services. For this extended absence option, urgently needed services obtained while temporarily absent from the geographic area and needed while the member is present in the affiliate organization's service area are the responsibility of the affiliate organization responsible for providing services to the member during the extended absence.

CMS approves extended absence options as part of the cost plan's initial Medicare application, or as such options are developed. CMS also reviews marketing materials and membership rules to ensure that the options are clearly explained and beneficiaries are advised of the distinction between authorized and unauthorized out-of-plan service use.

If a plan wants to offer an extended absence option, CMS suggests that the cost plan have the individual sign an agreement which states any restrictions on services imposed, where and how to obtain services, and how billing is accomplished.

Supplemental benefits for which the member is paying a premium may be discontinued upon his or her leaving the service area, as long as the member is not required to continue paying the premium or portion of a premium that corresponds to these services.

If a member takes advantage of the extended absence option, but fails to return to the service area within one year, the plan must disenroll him or her effective the first day of the month following the 1 year anniversary date of the original departure from the service area. The plan should notify the beneficiary regarding the upcoming disenrollment before it occurs.

50.2.2 – Death

CMS will disenroll deceased members effective the month immediately following the month of death and notify the cost plan that the member has expired. Monthly interim per capita payments end with that month. The plan should send a notice to the member or his or her estate so that any disenrollment due to an erroneous report of death can be corrected as soon as possible (Exhibit 9).

If the plan obtains reliable information regarding the death of a member from a source other than CMS, such as a copy of an official death certificate, it may notate this in the cost plan's internal systems for customer service purposes, such as to suppress premium billing. The cost plan may not submit a disenrollment transaction to CMS based on a report of death; CMS will obtain this information directly from SSA (or RRB) and take the appropriate action in its systems.

50.2.3 – Loss of Entitlement to Part B

The member is disenrolled by CMS the month immediately following the month that enrollment in Part B ends. Monthly interim per capita payments made on behalf of the beneficiary terminate effective the month immediately following the last month of entitlement to benefits under Part B. The plan should send a notice to the member so that any disenrollment due to erroneous information can be corrected as soon as possible (Exhibit 10). The beneficiary may remain a member of the organization if a non-Medicare option is available.

If a member loses entitlement to benefits under Part A, but remains entitled to benefits under Part B, he or she remains a member of the cost plan. The member is entitled to receive and have payment made for Part B services only, beginning with the month immediately following the last month of his or her entitlement to Part A. The cost plan may offer all or partial Medicare Part A benefits.

50.2.4 – Plan Termination/Non-Renewal or Reduction of Plan Service Area

A cost plan must disenroll members from its plan if the contract is terminated, if the organization discontinues offering the plan, or if the plan does not renew in any portion of the area where it had previously been available.

A member who is disenrolled from a cost plan under these provisions is allowed to choose another cost plan or an MA organization (if one is available and he/she meets applicable eligibility requirements), or original Medicare. If no other choice is made, the individual will automatically return to Original Medicare by default.

Notice Requirements: In most cases, the plan terminating the contract must send a written notice to all Medicare members enrolled in the organization at least 60 days before the effective date. However, if CMS initiates a termination, it notifies members 30 days before the effective date.

The notice must be reviewed by CMS prior to issuance. The plan must submit the proposed notices for review in sufficient time to meet all deadlines, and provide final copies of the notices sent to beneficiaries to the CMS Regional Office account manager.

The termination, non-renewal, or partial non-renewal of a contract between the plan and CMS, whether by mutual consent or by unilateral action of either party, ends the liability of CMS to make monthly interim per capita payments on behalf of Medicare beneficiaries. CMS' liability ends effective the first day of the month following the last month the contract is in effect.

If the cost plan defaults on its contract with CMS prior to the close of the contract year due to bankruptcy or other reasons, CMS will establish the month in which interim per capita payments end

for all enrolled Medicare beneficiaries. CMS will notify the cost plan and all affected Medicare enrollees in writing as soon as practical.

50.2.5 – Failure to Pay Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA)

Individuals with Part D-IRMAA must pay this additional amount directly to the government, not to the plan providing the Part D coverage. CMS has established a 3-month initial grace period before individuals who fail to pay their Part D-IRMAA will be disenrolled from their Part D coverage. CMS will report the disenrollments to the organization via the daily TRR using a specific Transaction Reply Code (TRC). The effective date of the Part D coverage disenrollment is the first of the month following the end of the initial grace period.

Individuals enrolled in a cost contract and an optional supplemental Part D benefit offered by the cost plan who fail to pay their assessed Part D-IRMAA will be disenrolled from the cost contract, as directed by CMS via the TRR using a specific TRC.

Similar to instances in which a cost plan enrollee is automatically disenrolled when he or she enrolls in a standalone PDP, CMS directs cost plans to submit a transaction to CMS to enroll the individual in the cost contract without the Part D optional supplemental benefit (i.e. “cost-only PBP”). The action the cost plan takes to submit an enrollment transaction to return the individual to the Cost-only plan should be transparent to the individual.

The cost plan must send each affected individual a written notice of the loss of the optional supplemental Part D benefit within ten (10) calendar days of receipt of the TRR indicating disenrollment for non-payment of the Part D-IRMAA. (See Exhibit 21)

For more information on disenrollment for failure to pay the Part D-IRMAA, see Chapter 3 of the Medicare Prescription Drug Benefit Manual.

Reinstatement for Good Cause – Individuals whose optional supplemental Part D benefit ends because they failed to pay Part D-IRMAA have the opportunity to ask CMS to reinstate the optional supplemental benefit. CMS may reinstate the benefit, without interruption of coverage, if the individual demonstrates good cause and pays **in full** within three (3) calendar months of the date the benefit ended:

- The Part D-IRMAA amounts that caused the loss of the optional supplemental Part D benefit for failure to pay Part D-IRMAA, and
- Any plan premium amounts or other charges owed at the time the benefit ended.

For more information on Good Cause, see §60.6.3.

50.2.6 – Unlawful Presence Status

The cost organization cannot retain a member in a cost plan if the member is not lawfully present in the United States. The organization may not request from a member any documentation of U.S. citizenship or alien status, as CMS provides the official status to the cost organization. CMS will

notify the organization (via *D*TRR) that the individual is not lawfully present, and CMS will make the disenrollment effective the first day of the month following the month following the notification by CMS.

Notice Requirements – Following the receipt of a CMS notification (via *D*TRR) of the disenrollment due to unlawful presence, CMS strongly suggests that a notice be provided within 10 days of receipt of the *D*TRR (see Exhibit 25) so that the member is aware of the loss of coverage in the plan and any erroneous disenrollments can be corrected as soon as possible. See §60.6.1 for cases of possible erroneous disenrollment or notification.

50.3 – Other Involuntary Disenrollments

The cost plan may disenroll a member from the plan in the following cases:

- The member fails to pay premiums or other charges (§50.3.1);
- The member commits fraud or permits abuse of his or her enrollment card (§50.3.2); or
- Cause (Disruptive Behavior) (§50.3.3).

50.3.1 – Failure to Pay Premium

42 CFR 417.460(c) and Section 504 of the Rehabilitation Act of 1973
(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Cost plans have the following options when a member does not pay his or her basic monthly premium (or other charges for deductible and coinsurance amounts for which the member is liable.) The cost plan should outline its policy in its policy and procedures and apply the option chosen consistently among all members.

1. Do nothing (i.e., allow the member to remain enrolled in the same premium plan); or
2. Disenroll the member after proper notice.

The cost plan may disenroll a Medicare beneficiary who fails to pay his or her basic monthly premiums, or other charges imposed by the cost plan for Medicare deductible and coinsurance amounts for which he or she is liable. However, the cost plan must demonstrate to CMS that a reasonable effort was made to collect the unpaid amount and that the plan gave the beneficiary written notice of disenrollment before notifying CMS. Since it is possible that the beneficiary believes that nonpayment of premiums is a way to disenroll, the cost plan may wish to include in its payment reminder notices an explanation of the proper way to disenroll. CMS will consider the cost plan to have demonstrated reasonable effort in collecting unpaid premiums if the plan mails a notice of disenrollment for nonpayment of premium to the beneficiary at least 20 days before the effective date of disenrollment. This allows 5 days for mailing time and 15 days for the beneficiary to act on the notice.

NOTE: For individuals who have requested communications in an accessible format, the timeframe for demonstrating a reasonable effort cannot begin until the organization provides notification (or the bill) to that member in the format which he or she can read.

Disenrollment for nonpayment of premium will be effective as of the last day of the month in which the payment period (or at least 20 days) expires. The plan should include in any disenrollment

communications an explanation of the member's rights to a hearing under its grievance procedures and the ability to request reinstatement for good cause. (See Exhibit 19) The cost plan may not notify CMS until after the plan has notified the beneficiary. The cost plan is strongly encouraged to send the beneficiary a disenrollment confirmation notice (See Exhibit 20).

NOTE: If the member fails to pay the premium for optional supplemental benefits, but pays the premium for the basic benefits, the cost plan may not disenroll him or her from the cost plan contract. The cost plan may discontinue the optional benefits, but may not disenroll the member from the cost plan. If the optional supplement benefit is a Part D benefit, the cost plan must discontinue services and disenroll the individual from that optional supplemental benefit (see Exhibit 19a) consistent with 42 CFR 423.44(d).

If the individual is involuntarily disenrolled for failure to pay premiums, payment of past due premiums after the disenrollment date does not create an opportunity for reinstatement into the plan from which the individual was disenrolled for failure to pay premiums. See §60.6.3 for more information about good cause reinstatements after disenrollment for failure to pay premiums.

50.3.2 – Fraud in Enrollment or Abuse of Membership Cards

A Medicare beneficiary may be disenrolled if he/she commits fraud in connection with his or her enrollment or permits abuse of the membership card, e.g., the beneficiary knowingly provides fraudulent information on the application form, which materially affects eligibility for enrollment, or a Medicare beneficiary permits others to use his or her membership card to receive services. This category includes any abuse relating to cost plan membership or the Medicare program.

In the case of fraud or abuse, the cost plan must send the beneficiary written notice of termination prior to submission of the disenrollment notice to CMS. The plan must include an explanation of the member's rights to a hearing under grievance procedures established by the organization, and also notify the RO so that the Office of the Inspector General may initiate its own investigation of the alleged fraud or abuse.

50.3.3 – Disenrollment for Cause (Disruptive Behavior)

A cost plan may request CMS review of a proposed disenrollment of a Medicare member if his or her behavior is disruptive, unruly, abusive, or uncooperative to the point that his or her continuing membership seriously impairs the ability to furnish services to either him/her or other members. The cost plan must meet all the requirements of this section.

The cost plan must ascertain that the enrollee's behavior is not related to the use of medical services or to mental illness. The cost plan may not disenroll a member because he/she exercises the option to make treatment decisions with which the cost plan disagrees, including the option of no treatment and/or no diagnostic testing. The cost plan may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the cost plan or any health care professionals associated with the cost plan.

Before requesting CMS' approval of disenrollment for disruptive behavior, the cost plan must make a serious effort to resolve the problems presented by the member. Such efforts must include providing

reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. The cost plan must also inform the individual of his or her right to use the organization's grievance procedures.

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

- Of the disruptive behavior;
- Of the cost plan's serious efforts to resolve the problem with the individual;
- Of the cost plan's effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act;
- Establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Describing any extenuating circumstances cited under 42 CFR 417.460(e)(3);
- Of any written notices that the cost plan provided the member regarding the consequences of continued disruptive behavior (see Member Notices); and
- Of any written notice that the cost plan provided of its intent to request involuntary disenrollment (see Member Notices).

The cost plan must submit to its CMS Regional Office account manager:

- The above documentation;
- The thorough explanation of the reason for the request detailing how the individual's behavior has impacted the cost plan's ability to arrange for or provide services to the individual or other members of the cost plan;
- Member information, including age, diagnosis, mental status, functional status, a description of his or her social support systems and any other relevant information;
- Statements from providers describing their experiences with the member; and
- Any information provided by the member.

The cost plan may request that CMS consider prohibiting re-enrollment in the cost plan or other plans offered by the cost plan's parent organization in the service area.

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

The Regional Office will obtain Central Office concurrence before approving an involuntary disenrollment. The disenrollment is effective the first day of the calendar month after the month in which the organization gives the member a written notice of the disenrollment, or as provided by CMS. Any disenrollment processed under these provisions will always result in a change of enrollment request to Original Medicare.

If the request for involuntary disenrollment for disruptive behavior is approved, CMS may require the cost plan to provide reasonable accommodations to the individual in such exceptional circumstances that CMS deems necessary. An example of a reasonable accommodation in this context is that CMS could require the cost plan to delay the effective date of involuntary disenrollment to coordinate with a cost plan enrollment request or Part D enrollment period that would permit the individual an opportunity to obtain other coverage.

Member Notices

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

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

Advance Notice

Prior to forwarding an involuntary disenrollment request to CMS, the cost plan should provide the member with written notice describing the behavior it has identified as disruptive and how it has impacted the cost plan's ability to arrange for or provide services to the member or to other members of the cost plan. The notice should explain that his or her continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action. The cost plan should include a copy of this notice and the date it was provided to the member in any information forwarded to CMS. **NOTE:** If the disruptive behavior ceases after the member receives notice and then later resumes, the cost plan must begin the process again. This includes sending another advance notice.

Notice of Intent

If the member's disruptive behavior continues despite the cost plan's efforts, then the cost plan should notify him/her of its intent to request CMS' permission to disenroll him/her for disruptive behavior. This notice should also advise the member of his or her right to use the organization's grievance procedures and to submit any information or explanation. Refer to Chapter 13, "Grievances, Organizations Determinations, and Appeals," for the appropriate procedures for grievances. The cost plan should include a copy of this notice and the date it was provided to the member in any information forwarded to CMS.

Planned Action Notice

If CMS permits a cost plan to disenroll a member for disruptive behavior, the cost plan should provide the member with a written notice that contains, in addition to the notice requirements outlined in §50.3, a statement that this action was approved by CMS and meets the requirements for disenrollment due to disruptive behavior. The cost plan may only provide the member with this required notice after CMS notifies the cost plan of its approval of the request.

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

60 – Post-Enrollment/Disenrollment Activities

60.1 – Retroactive Enrollments

In general, retroactive enrollments are not accepted by CMS. If the cost plan has informed a beneficiary that his or her enrollment in the plan is effective on a certain date, but then submits an incorrect enrollment transaction to CMS, the plan must honor its contract with the individual and begin providing coverage on the stated date. If the plan provides services to the member before it can submit the correct enrollment information, the plan may still receive Medicare fee-for-service (FFS) payments for any services it renders. In order for the cost plan to receive direct payments for physician and supplier services from a Medicare carrier, the cost plan must have a third party billing number.

Each month, CMS will make an interim per capita payment to the plan based on the number of members enrolled in the plan. At the end of the contract period, the plan must submit a Cost Settlement Report to CMS (please see Chapter 17-Subchapter A, §20.2, of the Medicare Managed Care Manual for further details on the Report). The report will allow the cost plan to report any underpayments or overpayments due.

However, there are situations where CMS may make an exception. CMS will review these situations on a case-by-case basis and will generally only grant exceptions for incorrect entitlement data or other types of CMS systems problems.

60.1.1 – Enrollment Retroactive to Date of Initial Medicare Entitlement

The effective date of membership as a Medicare beneficiary is the month in which the individual becomes entitled to benefits under Medicare Part A and is enrolled in Medicare Part B, or enrolled in Medicare Part B only if:

- The individual enrolls in Part B of Medicare and applies to the cost plan prior to the month in which he/she is entitled to part B of Medicare; or
- The individual is a member of the cost plan organization prior to his or her entitlement to Medicare benefits and applies to the cost plan prior to the month of entitlement.

Some beneficiaries may not have a record of entitlement to Part B established in the data system at CMS until after the actual date of first entitlement. In such cases, CMS will take action to correct the effective date retroactively.

60.1.2 – Errors in Social Security Administration (SSA) Records and/or CMS Medicare Entitlement Data

In some instances, problems may occur that are related to SSA and/or CMS systems. The cost plan may request a retroactive enrollment when SSA/CMS systems problems delay processing of applications. These include:

1. Application rejection when Part B entitlement is not reflected on Medicare records prior to the first month of entitlement (due to possible lag time when a beneficiary enrolls during a special enrollment period instead of the initial enrollment period);
2. HIC number changes;
3. Erroneous death notifications;
4. Problems with posting of Medicare Part B premiums;
5. Erroneous incarceration or unlawful presence notifications; or
6. Any other SSA/CMS systems issue that may cause the Medicare entitlement data to be incorrect or missing or that may result in an erroneous enrollment rejection

The cost plan should submit requests for review of cases related to items 1 through 4 and item 6 to CMS. In the case of erroneous incarceration or unlawful presence notifications, for individuals who contest their denial of enrollment on these bases, the cost organization should check CMS' systems to see if the incarceration or unlawful presence status has been removed (via audit notification in MARx) and that the person is eligible for enrollment as of the enrollment effective date. If the beneficiary is otherwise eligible for enrollment, the retroactive enrollment request may be sent to the CMS Retroactive Processing Contractor. However, if the beneficiary continues to reflect an incarcerated or unlawful presence status in CMS systems, the cost plan should refer the beneficiary to the Social Security Administration so that they may review their records and make corrections, as appropriate.

60.2 – Retroactive Disenrollment

In general, CMS does not accept retroactive disenrollments. As discussed in §50.1.1 of this chapter, voluntary disenrollment must be effective no later than the first day of the month following receipt of the member's written request for disenrollment, unless the beneficiary requests a later date. If the beneficiary requests a later date, it can be no later than the third month after the month in which CMS receives an acceptable disenrollment request from the cost plan.

However, CMS may approve retroactive disenrollments for certain situations on a case-by-case basis. The plan should submit retroactive disenrollment requests, including supporting evidence justifying the late disenrollment, to CMS. If CMS approves the cost plan's request for retroactive disenrollment, the plan must reimburse the member for any premium paid for any month for which CMS processes a retroactive disenrollment.

The following are examples of situations where retroactive disenrollment may be permissible. This list contains examples; it is not meant to be all-inclusive, nor does it imply that retroactive disenrollment is assured for any circumstance:

- **Systems Problems** – If the beneficiary submits a proper disenrollment request, but as a result of systems problems the disenrollment is not shown on a timely basis in the cost plan's or CMS' records.
- **Organizational Error** – When the organization has not properly processed or acted upon the member's properly made disenrollment request. A disenrollment request will be considered not properly processed or acted upon if the effective date is a date other than as required in §50.1.1 of this chapter.

- **Lack of Intent to Enroll** – The cost plan must submit a retroactive disenrollment request to CMS if there is evidence that the beneficiary did not intend to enroll in the plan (e.g., the beneficiary did not realize he or she ever enrolled in a cost plan).

Evidence that the beneficiary did not intend to enroll may include:

- Continuing supplemental (Medigap) insurance coverage after the effective date of cost plan enrollment;
- Purchasing supplemental insurance immediately after enrolling in the plan; or
- Making an inquiry to CMS questioning cost plan enrollment.

Payment of the plan's premium does not necessarily indicate an informed decision to enroll. The beneficiary may believe that he or she was purchasing a supplemental health insurance policy. In addition, use of a plan doctor does not necessarily indicate an understanding of the cost plan's rules if the doctor also treats non-cost plan members.

60.2.1 – Failure of Employer Group to Notify Plan of Requested Disenrollment

The cost plan must submit a retroactive disenrollment request to CMS if an employer group fails to provide timely notification of a Medicare beneficiary's requested disenrollment. CMS may process disenrollments up to 90 days retroactively. The employer group's notification is untimely if it does not result in a disenrollment effective for the month following the month the request is received, or for the requested effective date (if later).

Evidence must demonstrate that the beneficiary acted to disenroll in a timely fashion (i.e. prospectively), but the employer group was late in providing the information to the cost plan. Such evidence may include an election or application form signed by the beneficiary and given to the employer group during an open enrollment season.

NOTE: The application form could be the employer group's generic form used during its open enrollment season for all employees and retirees.

60.3 – Multiple Transactions

Multiple transactions occur when CMS receives more than one enrollment transaction for the same individual with the same effective date in the same reporting period. An individual may not be enrolled in more than one MA, cost, PDP or HCPP plan at any given time (however, an individual may be enrolled in a cost plan and a separate PDP plan, or in certain other MA plan types and a separate PDP plan). Generally, the last enrollment action the beneficiary makes during an enrollment period will be accepted as the plan the individual intends to enroll in. The CMS will accept the enrollment action based upon the date that the enrollment application was signed or the enrollment request for MA or PDP plans was received. If the beneficiary does not date the enrollment form, the date the enrollment form was received by the cost plan will be used as the default date.

If an individual elects more than one plan for the same effective date and with the same signature or receipt date, the first transaction successfully processed by CMS will apply. Because simultaneous

enrollment in a cost plan and a separate PDP plan is permitted, CMS systems will accept both enrollments.

Generally, given the use of the application date to determine the intended enrollment choice, retroactive enrollments will not be processed for multiple transactions that reject because the elections were signed on the same day.

EXAMPLE 1

- Two Medicare managed care plans receive completed enrollment forms from one individual. Cost plan #1 receives the complete form on May 4th and cost plan #2 receives a complete form on May 10. Both cost plans submit enrollment transactions, including the applicable date. The enrollment in cost plan #2 will be the transaction that is accepted and will be effective on June 1 because the application date on the enrollment transaction is the later of the 2 submitted. Both plans receive the appropriate reply on the reply listing.

EXAMPLE 2

- Two Medicare managed care plans receive completed enrollment forms from one individual on August 13 for an October 1 effective date. Both enrollment forms were signed on August 8, and were transmitted by the August cutoff date with the same application date on the transaction. The first transaction successfully processed by CMS will be accepted; the second to arrive (with identical application and effective dates) will be rejected.

In the event a rejection for a multiple transaction is reported to the cost plan, the cost plan may contact the individual. If the individual wishes to enroll in the cost plan, he or she must fill out and sign another enrollment form. The cost plan may transmit the information to CMS using the appropriate effective date as described in §30.

60.4 – Storage of Enrollment Forms

The cost plan must retain enrollment forms while beneficiaries are members of the plan and for one year after disenrollment. Cost plans that offer an optional supplemental Part D benefit must retain the enrollment records for individuals who have elected that benefit for the current contract period and 10 (ten) prior periods (as described in the CMS PDP Enrollment and Disenrollment guidance, section 50.6).

It is appropriate to allow for storage on microfilm or by other technologies, such as optical scanning, as long as all forms and associated documents stored in this manner are legible, including the signature, and easily accessible by reviewers.

60.5 – Cancellations

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

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

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

60.5.1 – Cancellation of Enrollment

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

To ensure the cancellation is honored, the cost plan should not transmit the enrollment to CMS. If, however, the organization has already transmitted the enrollment by the time it receives the request for cancellation, it must submit a TRC 80 cancellation transaction to CMS to cancel the now-void enrollment transaction from the CMS enrollment system. In the event the cancellation transaction fails or the cost plan has other difficulty, the cost plan must contact CMS (or the CMS Retroactive Processing Contractor) in order to cancel the enrollment.

When canceling an enrollment transaction, the cost plan must provide a notice to the individual that states that the cancellation is being processed. The organization should send this notice within 10 calendar days of receiving the cancellation request.

If the member's request for cancellation occurs after the effective date of the enrollment in the cost plan, the cancellation generally cannot be processed. The organization must inform the individual that he or she is a member of its cost plan. An individual previously enrolled in an MA plan will have to request enrollment in that plan during a valid enrollment period for a prospective effective date.

Note that if the individual was enrolled in another plan prior to making the enrollment request (and cancelling that request), when the cancellation transaction occurs, CMS will attempt to reinstate the individual into the prior plan. See §60.6.2 for specifics regarding the reinstatement.

60.5.2 – Cancellation of Disenrollment

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

To ensure the cancellation is honored, the cost plan should not transmit the disenrollment to CMS. If, however, the organization had already transmitted the disenrollment by the time it receives the verbal request for cancellation, it may attempt to submit a TRC 81 cancellation of disenrollment transaction to CMS to cancel the now void disenrollment transaction. In the event the organization has submitted the disenrollment and is unable to submit the TRC 81, or has other difficulty, then the organization

should contact CMS (or the CMS Retroactive Processing Contractor) in order to cancel the disenrollment.

The cost plan must send a letter to the individual that states that the cancellation is being processed and that instructs the member to continue using plan services. This notice should be sent within 10 calendar days of receipt of the cancellation request.

If the member's request for cancellation occurs after the disenrollment effective date, the cancellation cannot be processed. The organization should instruct the member to complete a new enrollment form to enroll in the cost plan for a prospective effective date.

60.5.3 – Cancellation Due to Notification from CMS (TRC 015)

When a cost organization receives a TRC 015 (Enrollment Cancelled), it indicates that an enrollment must be cancelled. A cancellation may be the result of an action on the part of the beneficiary, CMS or another plan.

Within ten (10) days of receiving the TRC 015, the cost plan must send the individual an acknowledgment notice of the cancellation (Exhibit 23).

60.6 – Reinstatements

Reinstatements may be necessary under limited circumstances. The most common reasons potentially warranting reinstatements are:

1. Disenrollment due to erroneous death indicator (§60.6.1);
2. Disenrollment due to erroneous loss of Medicare Part B indicator (§60.6.1);
3. Disenrollment due to erroneous incarceration or unlawful presence information (§60.6.1);
4. Automatic reinstatement based on beneficiary cancellation of subsequent enrollment (§60.6.2);
5. Demonstration of good cause for failure to pay cost plan premiums (or other charges) or optional supplemental Part D benefit premiums or Part D-IRMAA timely (§60.6.3).

When a disenrolled individual contacts the cost plan to state that he or she was disenrolled due to item 1 (erroneous death indicator) or item 2 (erroneous loss of Medicare Part B indicator), and states that he or she wants to remain a member of the cost plan, the cost plan must instruct the member in writing to continue to use cost plan services (refer to Exhibits 17 and 18). The cost plan should send the notice within ten (10) calendar days of the individual's contact with the organization to report the erroneous disenrollment. Accordingly, plan systems should indicate active membership as of the date the organization instructs the individual to continue to use plan services.

When a disenrolled individual contacts the cost plan about either item 3 (erroneous incarceration or unlawful presence information), item 4 (reinstatement based on cancellation of new enrollment) or

item 5 (good cause), plans must follow the guidance outlined below pertaining to those unique situations.

CMS views a reinstatement as a correction necessary to “erase” an invalid disenrollment action. Therefore, reinstatements may be made back to a date when a cost plan was closed for enrollment.

When a cost organization receives notification of an individual’s reinstatement, the organization should send the individual a notice of reinstatement (Exhibit 16) within ten (10) calendar days.

60.6.1 – Reinstatements for Disenrollment Due to Erroneous Death Indicator, or Erroneous Loss of Medicare Part B, Erroneous Incarceration Information, or Erroneous Unlawful Presence Information

A member will be reinstated if he or she was disenrolled in error, since the individual continues to be eligible. This may occur in the following situations:

- Erroneous death indicator;
- Erroneous loss of Part B;
- Erroneous lawful presence status; or
- Erroneous incarceration information.

Cost plans have the option of sending the member notification of disenrollment due to:

- Death;
- Loss of B entitlement; or
- Unlawful presence in the U.S.

CMS strongly suggests that cost plans send these notices in these three situations, to ensure any erroneous disenrollments are corrected as soon as possible. Refer to Exhibits 17, 18 and 25 for model letters.

If CMS involuntarily disenrolls an individual due to incarceration, a notice is required because the individual resides out of the plan’s geographic service area. See §50.2.1 for notice requirements for disenrollment due to incarceration. Refer to Exhibit 24.

Erroneous disenrollments must be corrected and the corresponding reinstatements processed, regardless of the date on which the individual disputes the erroneous disenrollment or provides evidence of cost plan eligibility.

Reinstatements for erroneous death indicator or erroneous loss of Part B entitlement:

Individuals can dispute the disenrollment due to death indicator or loss of Part B entitlement. In such cases, the cost organization is expected to acknowledge the individual’s request for reinstatement and direct him or her to continue to use cost plan services while the issue is resolved with the Social Security Administration (SSA). Organizations may request that such individuals provide evidence of cost plan eligibility by a particular date; however, should the individual provide evidence after that date, the error must still be corrected by the cost organization.

To request reinstatement following disenrollment due to erroneous death indicator or erroneous loss of Medicare Part B, the cost plan must submit the reinstatement request to CMS (or its designee) and

should include a copy of the letter to the member informing him or her to continue to use cost plan services until the issue is resolved. The cost plan must indicate the date the letter was sent. Refer to model letters in Exhibit 17 and Exhibit 18.

Within ten (10) calendar days of receipt of *the Daily* Transaction Reply Report (*DTRR*) confirmation of the individual's reinstatement, the organization should send the member notification of the reinstatement (Exhibit 16).

CMS will attempt to automatically reinstate individuals that were auto-disenrolled by a report of date of death if there is a subsequent date of death correction that impacts the plan enrollment.

Reinstatements for erroneous incarceration information or lawful presence status:

Individuals alleging disenrollment due to erroneous incarceration information or erroneous lawful presence status must have their complaints reviewed by the cost plan and possibly referred to SSA. Cost plans are not required to provide coverage to such individuals while the issue is reviewed by the plan or SSA.

For individuals who contest their disenrollment on these bases, the cost organization should check CMS' systems to see if the incarceration or unlawful presence status has been removed (via audit notification in MARx) and that the person is otherwise eligible to remain enrolled as of the disenrollment effective date. If the individual is otherwise eligible for enrollment, the reinstatement request may be sent to the CMS Retroactive Processing Contractor (RPC) instead of referring the individual to SSA. However, if the CMS systems continue to reflect an incarcerated or unlawful presence status, the cost plan should refer the beneficiary to SSA so that they may review their records and make corrections, as appropriate. If the information or status is determined to be erroneous by SSA, CMS' systems will be updated. The plan may check CMS systems to see if the incarceration or unlawful presence status has been removed, and, if the person is otherwise eligible to remain enrolled, may send the reinstatement request to the CMS RPC. The cost organization will receive notification of the individual's reinstatement from CMS or via the *DTRR*. At that time, services should resume and coverage should be seamless, as though the individual was never disenrolled. CMS suggests that the organization send the member notification of the reinstatement (Exhibit 16) within ten (10) days of receipt of *DTRR* confirmation of the individual's reinstatement.

60.6.2 – Reinstatements Based on Beneficiary Cancellation of New Enrollment

As stated in §50.5, deliberate member-initiated disenrollments imply intent to disenroll. Therefore, reinstatements generally will not be allowed if the member deliberately initiated a disenrollment. An exception is made for those members who were automatically disenrolled because they enrolled in another plan but subsequently cancelled the enrollment in the new plan before it becomes effective.

In this situation, the individual must cancel the enrollment into the new plan, as described in section 60.5.2 or other CMS manual guidance. When a cancellation of enrollment in a new plan is properly made, the associated automatic disenrollment from the previous plan becomes invalid. Upon successful cancellation of enrollment in the new plan, CMS systems will attempt to automatically reinstate enrollment in the previous plan. Because this process is automatic, it is generally not necessary to request reinstatement via the Regional Office or Retroactive Processing Contractor.

Within ten (10) days of receipt of TRR confirmation of the individual's reinstatement, the organization should send the member notification of the reinstatement (Exhibit 16).

In cases where the valid, timely cancellation request is not processed correctly, or CMS systems cannot complete the otherwise-valid request, the new plan must submit a request to the CMS Retroactive Processing Contractor to cancel the enrollment. This request will require complete documentation, including evidence that the beneficiary requested cancellation of enrollment in the new plan within required timeframes.

If the previous plan becomes aware of an unsuccessful reinstatement, the previous plan may contact the CMS Retroactive Processing Center or CMS Account Manager to investigate the issue with the new plan.

If the disenrolled individual contacts the previous plan requesting to remain a member of that plan, the Cost plan should inform the individual that reinstatement of enrollment is an option only if the individual successfully cancels enrollment in the "new" plan; accordingly, the organization should refer the individual to the "new" plan to inquire about his or her options.

60.6.3 – Reinstatements Based on a Determination of Good Cause for Failure to Pay Cost Plan Premiums, Optional Supplemental Part D Benefit Premiums or Part D-IRMAA Timely

Starting in 2012, individuals who lost their optional supplemental Part D benefit due to either non-payment of the plan's Part D benefit premium (under §50.3.1 paragraph 3) or the assessed Part D-IRMAA amount to CMS (under §50.2.5) may request reinstatement of the Part D benefit for good cause. Starting January 1, 2013, individuals who are disenrolled from the cost plan as a result of failure to pay the plan's premium (or other charges) associated with the basic cost coverage (under §50.3.1) may also request reinstatement for good cause. Thus, starting with disenrollments effective January 1, 2013, the opportunity to request reinstatement for good cause is available to all individuals enrolled in cost contracts, including both those with or without the optional supplemental Part D benefit.

Reinstatement for good cause, pursuant to 42 CFR § 417.460(c)(3), will occur only when:

1. The individual requests reinstatement within 60 days of the effective date of disenrollment or loss of the optional supplemental Part D benefit;
2. The individual has been determined to meet the criteria specified below (i.e., receives a favorable determination); and
3. (a) Within three (3) months of disenrollment for nonpayment of plan premiums (or other charges), the individual pays **in full** the plan premiums (or other charges) owed at the time he or she was disenrolled;
(b) Within three (3) months of loss of the optional supplemental Part D benefit for nonpayment of plan premiums (or other charges), the individual pays **in full** the plan premiums (or other charges) owed at the time the optional supplemental Part D benefit ended; or
(c) Within three (3) months of loss of the optional supplemental Part D benefit for nonpayment of Part D-IRMAA, the individual pays **in full** the Part D-IRMAA amounts

owed at the time the optional supplemental Part D benefit ended and any plan premiums (or other charges) owed at the time the optional supplemental Part D benefit ended.

Individuals disenrolled for failure to pay plan premiums (or other charges) who had the optional supplemental Part D benefit must pay all owed premiums, including the amounts owed for the optional supplemental Part D benefit, in order to be reinstated into the cost plan. As reinstatement is a cancellation of the prior disenrollment, resulting in continuous enrollment, such an individual does not have an option to pay only the basic cost plan premiums (or other charges); the individual must retain all coverage options he or she had selected prior to being disenrolled.

Note: Individuals disenrolled for failure to pay plan premiums (or other charges) who had the optional supplemental Part D benefit and want to re-enroll in the cost plan without the optional supplemental Part D benefit may do so as a new election for a prospective effective date, provided the cost plan is open for enrollment and the individual meets all other criteria.

Criteria for Reinstatement: Reinstatement of enrollment or of the optional supplemental Part D benefit for good cause is provided only in rare circumstances in which the member or his or her authorized representative (i.e. the individual responsible for the member's financial affairs) was unable to make timely payment due to circumstances over which they had no control and they could not reasonably have been expected to foresee. Requests for reinstatement must be accompanied by a credible statement (verbal or written) explaining the unforeseen and uncontrollable circumstances causing the failure to make timely payment. An individual may make only one reinstatement request for good cause in the 60-day period.

Generally, these circumstances constitute good cause:

- A serious illness, institutionalization or hospitalization of the member or his or her authorized representative (i.e. the individual responsible for the member's financial affairs), that lasted for a significant portion of the period of time provided for payment of plan premiums (or other charges), premiums for the optional supplemental Part D benefit or Part D-IRMAA;
- Prolonged illness that is not chronic in nature, a serious (unexpected) complication to a chronic condition or rapid deterioration of the health of the member, a spouse, another person living in the same household, person providing caregiver services to the member, or the member's authorized representative (i.e., the individual responsible for the member's financial affairs) that occurs during the period of time provided for payment of plan premiums (or other charges), premiums for the optional supplemental Part D benefit or Part D-IRMAA;
- Recent death of a spouse, immediate family member, person living in the same household or person providing caregiver services to the member or to the member's authorized representative (i.e., the individual responsible for the member's financial affairs);
- Home was severely damaged by a fire, natural disaster or other unexpected event, such that the member or the member's authorized representative was prevented from making arrangement for payment during the period of time provided for payment of plan premiums (or other charges), premiums for the optional supplemental Part D benefit or Part D-IRMAA.
- An extreme weather-related, public safety or other unforeseen event declared as a Federal or state level of emergency prevented payment of premiums (or other charges) during the period of time provided for payment of plan premiums (or other charges), premiums for the optional supplemental Part D benefit or Part D-IRMAA. For example, the member's bank or U.S. Post Office closes for a significant portion of the period of time provided for premium payment; or

- For loss of the optional supplemental Part D benefit effectuated by CMS for failure to pay Part D-IRMAA, Federal government error (i.e., CMS, SSA or RRB) caused the payment to be incorrect or late, and the member was unaware of the error or unable to take action prior to the disenrollment effective date

There may be situations in addition to those listed above that result in favorable good cause determinations. If an individual presents a circumstance which is not captured in the listed examples, it must meet the regulatory standards of being outside of the member's control or unexpected such that the member could not have reasonably foreseen its occurrence, and this circumstance must be the cause for the non-payment of plan premiums (or other charges), premiums for the optional supplemental Part D benefit or Part D-IRMAA. CMS expects non-listed circumstances will be rare.

Examples of circumstances that do not constitute good cause include:

- Allegation that bills or warning notices were not received due to unreported change of address, out of town for vacation, visiting out of town family, etc.;
- Authorized representative did not pay timely on member's behalf;
- Lack of understanding of the ramifications of not paying plan premiums, other charges or Part D-IRMAA;
- Could not afford to pay premiums at the time of delinquency/disenrollment; or
- Need for prescription medicines or other plan services.

For examples of cases for favorable and unfavorable good cause determinations, see Appendix 3.

For the purpose of determining good cause for members with authorized representatives, the criteria for both favorable and unfavorable determinations apply as though the authorized representative is the member.

The inability to afford premiums or failure to make timely payment by a member or an authorized representative alone is not grounds for a favorable good cause determination and reinstatement. In addition, good cause determinations are not organization determinations related to coverage and, therefore, are not appealable (See 42 CFR 417.600). An individual may not make more than one reinstatement request for good cause in the same 60-day period following disenrollment, including instances in which the initial request resulted in an unfavorable determination. However, an individual has the right to file a grievance against the plan related to the involuntary disenrollment or loss of the optional supplemental Part D benefit.

An individual who has been disenrolled for failure to pay plan premium (or other charges), regardless of whether he or she has also been assessed Part D-IRMAA, remains disenrolled from the cost plan or the optional supplemental Part D benefit and does not have access to plan coverage of services until he or she receives a favorable good cause determination and the plan receives full payment of the plan premium amounts (and other charges) owed at the time he or she was disenrolled.

An individual who has lost the Part D optional supplemental benefit for failure to pay Part D-IRMAA remains without the optional supplemental Part D benefit and does not have access to Part D benefits until the reinstatement occurs and is reported to the cost plan on the TRR or the CMS caseworker contacts the cost plan after he or she has successfully updated the member's enrollment record in

MARx. Once a reinstatement occurs, the individual's loss of the Part D optional supplemental benefit will be cancelled and his or her optional supplemental Part D coverage will be continuous, assuming the individual continues to be eligible for that benefit.

60.6.3.1 - Process for Good Cause Determinations for Nonpayment of Plan Premiums (or other charges) or Optional Supplemental Part D Benefit Premiums

Pursuant to 42 CFR 417.460(c)(3), CMS has assigned the handling of good cause determinations to plans.

When an individual initially contacts the cost plan following disenrollment for failure to pay cost plan premiums (or other charges), or lost the optional supplemental Part D benefit due to failure to pay optional supplemental Part D benefit premiums, and states that he or she "has a good reason for not having paid the premiums," the cost plan must:

- Confirm that the request for reinstatement is being made within 60 calendar days of the disenrollment effective date or the date the optional supplemental Part D benefit ended;
- Inform the individual that reinstatement is a possibility only if it is determined that his or her failure to make timely payment was due to circumstances over which he or she had no control and could not reasonably have been expected to foresee;
- Obtain a credible statement from the individual regarding the circumstance that prevented him or her from making timely payment; and
- Obtain affirmation from the individual indicating his or her willingness and ability to pay all overdue plan premiums (or other charges) or optional supplemental Part D benefit premiums within three (3) months of the disenrollment date in order for reinstatement to occur.

If any of these preliminary requirements is not met, the individual is not eligible to be considered for reinstatement for good cause. An individual may not make more than one reinstatement request for good cause during the same 60-day period. For example, an individual requesting reinstatement indicates that he had no unusual or unexpected circumstance that caused the nonpayment of premiums and the plan determines that he does not qualify for his case to be reviewed under good cause. The plan is expected to clearly communicate that the individual's request will not be reviewed because the situation does not meet the criteria (e.g., not unusual or unexpected). The individual remains disenrolled (or without the optional supplemental Part D benefit if lost such coverage due to failure to pay those premiums) and may not make another request for good cause during the same 60-day period following the involuntary disenrollment (or loss of optional supplemental Part D benefit).

If all of the above criteria are met, the plan will review the request and will make a favorable or unfavorable good cause determination. CMS expects that plans make such determinations within five (5) business days of initial receipt of the request, so that the individual has a reasonable amount of time to make full payment for reinstatement. For requests received by mail, the initial request is considered received by the plan at the time it arrives in the cost plan's mailbox or mailroom. For requests received by fax, the initial request is considered received by the plan at the time when the fax is received on the cost plan's fax machine. For requests received by telephone, the initial request is considered received by the plan at the time the cost plan's representative receives the incoming call.

There is no additional time allotted for plans to gather information not collected at the point of initial contact. Plans would need to collect any additional data they feel is needed to make a determination and make that determination within five (5) business days of the date on which the individual first contacts the plan. In such cases where the plan does not have sufficient information to determine if the member's circumstances meet the requirements, it should make a good faith effort to collect it within that timeframe (e.g., making multiple attempts on different days and at different times). However, if attempts are unsuccessful, the plan must use the information provided with the initial request to make its determination.

If the plan makes a favorable determination and there are amounts owed to the plan for past due premiums, the plan should notify the individual of this decision within three (3) business days of making the determination. If the plan offers immediate payment options, such as payment by credit card via phone, it may provide the notification verbally; however, if the individual does not complete the payment at that time, the plan should issue a written notice to ensure that the individual has the information necessary to pay the owed amounts. This notice will specify the amount owed (i.e., the premiums owed at the time of disenrollment or loss of Part D), the date by which payment must be received for reinstatement (i.e., last day of the third month following the effective date of disenrollment or loss of Part D), where to send payment, and other payment options, such as credit card or direct withdrawal from a bank account, if offered by the plan. (See Exhibit 22).

If, at the time the plan makes a favorable determination, there are no amounts owed to the plan for past due premiums, the plan should notify the individual of this decision either verbally or in writing within three (3) business days of making the determination. Exhibit 22d is a model notice for the scenario in which an individual receives a favorable good cause determination and has already paid the amount required for reinstatement. If verbal notification is attempted but unsuccessful, a written notice should be provided. Verbal notification must be documented by the plan to meet CMS' retroactive processing contractor reinstatement submission requirements.

If the plan makes an unfavorable determination, the plan should notify the individual of this decision by phone or in writing within three (3) business days of making the determination.

If an individual has received a favorable good cause determination, reinstatement in CMS systems may not occur until and unless all required payments are made within three (3) months of the effective date of disenrollment or loss of Part D. If the individual pays all the owed amounts prior to the three-month deadline, the plan should resume coverage at that time and submit the reinstatement request to the CMS Retroactive Processing Contractor.

Plans have additional time beyond the payment deadline (i.e., three (3) months from the effective date of disenrollment or loss of Part D) to verify payment by the bank and credit the payment to the member's account. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five calendar days beyond the payment deadline to process the payment and submit the reinstatement request to the CMS Retroactive Processing Contractor.

Reinstatements for good cause are considered complete by CMS when TRC 287 (Enrollment Reinstated) is sent by CMS to the plan.

Within ten (10) calendar days of receipt of TRR confirmation of the individual's reinstatement, the cost plan should send the member notification of the reinstatement (See Exhibit 16). In an effort to

prevent members from falling behind in premium payments in the future, plans are encouraged to educate them on any automated payment mechanisms their plan offers, as well as the availability of selecting automatic premium withhold through their SSA or RRB benefits.

An individual may not be reinstated in cases where:

- the individual pays all cost plan or optional supplemental Part D benefit premium amounts owed, but does not receive a favorable good cause determination; or
- the individual receives a favorable good cause determination, but does not pay the cost plan or optional supplemental Part D premiums owed within three months of the effective date of disenrollment or loss of Part D.

In both of these cases, the plan may re-enroll the individual for a prospective enrollment effective date at the individual's request (using an appropriate enrollment request mechanism and assuming the cost plan is open for enrollment), following enrollment procedures outlined in Sections 30 and 40. Individuals who wish to obtain prescription drug coverage through the cost plan's optional supplemental Part D benefit must have a valid Part D election period. See Chapter 3 of the Medicare Prescription Drug Benefit Manual for more information on Part D election periods.

Example A: Mr. Smith's optional supplemental Part D benefit ends as of April 1 for failure to pay optional supplemental Part D premiums and he remains enrolled in the cost plan's basic medical benefit. Mr. Smith contacts the plan and makes his request on April 15 and receives a favorable good cause determination on April 23. The cost plan notifies Mr. Smith of the favorable determination and of the amount he owes by June 30 to be reinstated into the optional supplemental Part D benefit. Mr. Smith pays the amount due on June 15. Mr. Smith is reinstated into the optional supplemental Part D benefit. (Note: If Mr. Smith did not pay his owed amount by June 30, he would not be reinstated.)

Example B: Mr. Smith's optional supplemental Part D benefit ends as of July 1 for failure to pay the optional supplemental Part D premium and he remains enrolled in the cost plan's basic medical benefit. Mr. Smith mails in his past due amounts to the cost plan on July 30. He contacts the plan and makes his request on August 10, and does not receive a favorable good cause determination. Mr. Smith may not be reinstated.

Example C: Mr. Smith is disenrolled by the cost plan effective November 1 for failure to pay cost plan coinsurance amounts. Mr. Smith mails in his owed amounts to the cost plan on December 15, but does not contact the plan to request reinstatement. Thus, Mr. Smith does not have a favorable good cause determination, and he may not be reinstated in the cost contract.

Note: In cases where the loss of the optional supplemental Part D premium is the result of plan error, cost plans should follow the reinstatement process outlined in §60.2.3 of Chapter 3 of the Medicare Prescription Drug Benefit Manual. Plans should not refer these individuals to 1-800-MEDICARE, nor should these cases be considered for reinstatement for good cause.

60.6.3.2 – Process for Reinstatement of Optional Supplemental Part D Benefit Based on a Determination of Good Cause for Nonpayment of Part D-IRMAA

When an individual contacts the cost plan because his or her optional supplemental Part D benefit ended due to failure to pay Part D-IRMAA and indicates that he or she “has a good reason for not paying the Part D-IRMAA,” the cost plan must advise the individual to contact 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) within 60 calendar days of the date the optional supplemental Part D benefit ended to make the good cause reinstatement request. The plan should also inform the individual that in order to reinstate the optional supplemental Part D benefit, he or she must meet specific good cause standards and must pay all overdue Part D-IRMAA amounts within three months of the date the optional supplemental Part D benefit ended in order to have the Part D benefit reinstated.

Once a request is made with CMS via 1-800-MEDICARE, a CTM case will be generated for CMS caseworker action. The CMS caseworker will review the request and will make a favorable or unfavorable good cause determination. If the individual provides any documentation to the cost plan regarding the inability to make timely payment, the cost plan must provide that documentation to CMS (through the cost plan’s CMS account manager) so that the caseworker may consider it when making the determination. CMS will notify the individual of the determination and, if favorable, explain the general process, including payment responsibilities and timing. Cost plans are required to provide more specific information to the individual, as outlined below. If CMS makes an unfavorable determination, CMS will notify the individual of the determination. Notes of the good cause reinstatement request will be captured in the CTM for CMS and plan viewing.

Note: Requests for reinstatement of the optional supplemental Part D benefit are not considered complaints against the cost plan; therefore, these types of CTM cases are excluded from tracking for the purposes of cost plan ratings.

If CMS makes a favorable determination, a notation will be made in the CTM and the CTM will be sent to the plan. If there are amounts owed to the cost plan for premiums and other charges (optional supplemental Part D benefit premiums), the cost plan must send notification to the individual within three (3) business days of being informed of the favorable good cause determination. This notice will specify the amount owed, the date by which the cost plan must receive the payment to allow reinstatement (i.e., last day of the third month following the date the optional supplemental Part D benefit ended), and where to send payment (or other payment options such as credit card or direct withdrawal from a bank account) (See Exhibit 22).

Plans have additional time beyond the payment deadline (i.e., three months from the date the optional supplemental Part D benefit ended) to verify payment by the bank and credit the payment to the individual’s account. To provide adequate protections for individuals who make timely payment of their owed amounts, plans have five (5) calendar days beyond the payment deadline to process the payment and notify CMS via CTM. Even if an individual has received a favorable good cause determination, the actual reinstatement will not occur until all required payments are made within three (3) months of the date the optional supplemental Part D benefit ended.

Within ten (10) calendar days of receipt of TRR confirmation of the individual’s reinstatement, the cost plan should send the member notification of the reinstatement (See Exhibit 16). In an effort to prevent members from falling behind in premium payments in the future, plans are encouraged to

educate them on any automated payment mechanisms their plan offers, as well as the availability of selecting automatic premium withhold through their SSA or RRB benefits.

An individual's optional supplemental Part D benefit may not be reinstated in cases where:

- the individual pays all Part D-IRMAA amounts and any plan premium amounts (or other charges) owed, but does not receive a favorable good cause determination; or
- the individual receives a favorable good cause determination, but does not pay the Part D-IRMAA amounts and any plan premiums (or other charges) owed within three (3) months of the date of the loss of the Part D benefit.

Individuals who wish to obtain prescription drug coverage through the cost plan's optional supplemental Part D benefit may request it for a prospective effective date but must have a valid Part D election period. See Chapter 3 of the Medicare Prescription Drug Benefit Manual for more information on Part D election periods.

Example: CMS takes action to end Mr. Smith's optional supplemental Part D benefit effective August 1 due to his failure to pay Part D-IRMAA; he remains enrolled in the cost plan's basic medical benefit. He contacts Medicare and makes his request on September 29 and receives a favorable good cause determination on October 5. Mr. Smith is also delinquent on his optional supplemental Part D benefit premiums. CMS notifies Mr. Smith of the Part D-IRMAA amount he needs to pay by October 31. The cost plan also notifies Mr. Smith of the optional supplemental Part D benefit premium amount he needs to pay by October 31. Mr. Smith pays his Part D-IRMAA owed amount on October 25. Mr. Smith pays his optional supplemental Part D benefit premium owed amount on November 5. Because the plan received Mr. Smith's payment after the due date, Mr. Smith may not be reinstated. (Note: If Mr. Smith had paid both his owed Part D-IRMAA and optional supplemental Part D benefit premiums by October 31, the plan would have had the additional five (5) days to process the payment and he would have been reinstated.)

Appendix 1: Summary of Exhibits

This information provides a summary of the model notices and forms referenced in this chapter. For exact details on requirements and any applicable time frames, refer to the appropriate sections within this Chapter. Please refer to Chapter 17 for information on cost plan marketing material review.

Exhibit	Notice	Section	Required?	Timeframe
1	Model Cost Plan Enrollment Form	40.1.1	Yes	N/A
2	Model Notice to Acknowledge Receipt of Completed Enrollment Request	40.4 40.4.1	Yes	< 30 days from the date the form was received
3	Model Notice to Request Information	40.2.2 40.4	No	N/A
4	Model Notice to Confirm Enrollment	40.4 40.4.1	Yes	Within 30 days from receipt of CMS confirmation
5	Model Notice for Denial of Enrollment	40.4 40.5	Yes	7 business days following denial made when additional information request period ends
5a	Model Notice for Denial of Enrollment in Optional Supplemental Part D Benefit	40.5.1	Yes	Within 10 calendar days of receipt of selection request.
6	Model Notice to Send Out Disenrollment Request	50.1	No	N/A
6a	Model Disenrollment Request	50.1	No	N/A
7	Model Notice to Acknowledge Receipt of Member's Voluntary Disenrollment Request	50.1.1	No ¹	
8	Model Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing	50.1.1	No	Encouraged to send within 7 days of the availability of the reply listing
8a	Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan	50.1.1	No	Encouraged to send within 7 days of the availability of the reply listing
9	Model Notice of Disenrollment Due to Death	50.2.2	No	N/A
10	Model Notice of Disenrollment Due to Loss of Medicare Part B	50.2.3	No	N/A
11	[Moved to Appendix 2]	N/A	N/A	N/A
12	Model for Closing Enrollment	30.1 30.1.4	N/A	N/A

¹ However, the cost plan must provide the member with a copy of his or her disenrollment request.

Exhibit	Notice	Section	Required?	Timeframe
13	Model Notice to Inform Full Benefit Dual Eligible Member of Auto-Enrollment	40.1.5	Yes	As described in §40.1.5
13a	Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP	40.1.5	Yes	As described in §40.1.5
14	Model Notice to Inform Member of Facilitated Enrollment	40.1.5	Yes	As described in §40.1.5
14a	Model Notice to Inform Other LIS Eligible Member of Auto-Enrollment in PDP	40.1.5	Yes	As described in §40.1.5
15	Acknowledgment of Request to Decline Part D	40.1.5	Yes	As described in §40.1.5
16	Model Confirmation of Reinstatement	60.6, 60.6.1, 60.6.2, 60.6.3,	No	Encourages plan to send within ten (10) days of receipt of <i>D</i> TRR confirmation of the individual's reinstatement.
17	Model Notice to Offer Beneficiary Services Pending Correction of Erroneous Death Status	60.6 60.6.1	No	As described in §60.6.1
18	Model Notice to Offer Beneficiary Services Pending Correction of Erroneous Medicare Part B Termination	60.6, 60.6.1	No	As described in §60.6.1
19	Notice of Failure to Pay Plan Premiums (or other charges) – Notification of Disenrollment from Cost Plan Contract	50.3.1	Yes	At least 20 days prior to the effective date of the disenrollment.
19a	Notice of Failure to Pay Premiums – Notification of Loss of Optional Supplemental Part D Benefit	50.3.1	Yes	At least 20 days prior to the effective date of the loss of Part D.
20	Notice of Confirmation of Involuntary Disenrollment from Cost Plan Contract for Failure to Pay Plan Premiums	50.3.1	No	N/A
21	Notification of Loss of Optional Supplemental Part D Benefit by the Centers for Medicare & Medicaid Services for Failure to Pay the Part D-Income Related Monthly Adjustment Amount	50.2.5	No	Within ten (10) calendar days of the availability of the TRR.

Exhibit	Notice	Section	Required?	Timeframe
22	Model Notice on Favorable Good Cause Determination for Loss of Optional Supplemental Part D Benefit Due to Nonpayment of Part D-IRMAA – Notification of Premium Amount Due for Reinstatement	60.6.3	No	Within three (3) business days following the notification by CMS of favorable Good Cause determination
22a	Model Notice on Favorable Good Cause Determination – Notification of Premium Amount Due for Reinstatement of Cost Plan Contract	60.6.3	No	Within three (3) business days of favorable Good Cause determination
22b	Model Notice on Unfavorable Good Cause Determination Due to Nonpayment of Plan Premiums	60.6.3	No	Within three (3) business days of unfavorable Good Cause determination
22c	Model Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums within 3 Months of Disenrollment	60.6.3	Yes	Within (10) calendar days of the expiration of the 3 month period
22d	Model Notice on Favorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (No Plan Premium Amount Due for Reinstatement)	60.6.3	No	Within three (3) business days of favorable Good Cause determination
23	Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015)	60.5.3	Yes	Within ten (10) calendar days of the availability of the <i>D</i> TRR.
24	Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Incarceration	50.2.1	Yes	Within ten (10) calendar days of the availability of the <i>D</i> TRR.
25	Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence	50.2.6	No	Within ten (10) calendar days of the availability of the <i>D</i> TRR.

Appendix 2: Model Capacity Waiver Calculation Worksheet

1. Start with total capacity for the year that the waiver is requested (i.e., how many slots are available for both commercial and Medicare).
2. Current total (Medicare/Medicaid and commercial) membership, excluding estimated number of "age-ins" (i.e., non-Medicare enrollees of your plan who will convert to Medicare status during the period for which you are seeking a capacity waiver).
3. Projected new Medicaid-only and commercial individual or group members.
4. Add steps (2) and (3) and subtract result from step (1) above to determine remaining slots available.
5. Divide the figure in step (4) above by the utilization factor or factors from the most recent ACR to determine available slots for Medicare enrollees. Use an inpatient factor and ambulatory factor, or both. However, if both are used, the data must be shown separately for each one, or show an acceptable methodology for combining the factors.
6. The resultant figure is the initial number of available Medicare slots.
7. Enter estimated Medicare enrollment from "age-ins."(Current members excluded from (2) above.
8. Subtract step (7) from step (6). The result is the total number of slots available to individual Medicare members.

Appendix 3: Examples of Good Cause Determinations

Referenced in section: 60.6.3

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 §60.6.3.

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

Favorable determination examples:

Example A: Ms. Grey was disenrolled from the cost contract on May 31, 2015 following proper notice. 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 2015 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 period of time prior to disenrollment, 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 period of time prior to disenrollment; 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 prior to disenrollment as a result of the illness and hospitalization.

Example B: Mr. Lieber was disenrolled on April 30, 2015 following proper notice. 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 period of time prior to disenrollment, 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 period of time prior to disenrollment; 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 prior to disenrollment as a result of the illness.

Example C: Ms. Kim was disenrolled on August 31, 2015 following proper notice. 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 period of time just prior to disenrollment. 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 to conclude that the damage to Ms. Kim's home impaired her ability to pay or make arrangements to pay the owed premiums prior to disenrollment.

Example D: Mr. Jones was disenrolled on June 30, 2015 following proper notice. 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 prior to disenrollment.

Example E: Ms. Brown was disenrolled on July 31, 2015 following proper notice. 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 of time prior to disenrollment. 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 prior to disenrollment.

Example F: Mrs. Duke was disenrolled on August 31, 2015 following proper notice. She states that her husband had been handling her bills and making payments timely. However, he passed away in July 2015, 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 prior to disenrollment.

Example G: Mr. Santiago lives in Lucas County, Iowa, and was disenrolled on July 31, 2015 following proper notice. He states that there were severe storms and significant flooding in his town and the Post Office closed for a week during the period of time just prior to disenrollment, 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 period of time just prior to the disenrollment 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; 2) The event (declared state of emergency) 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 prior to disenrollment.

Unfavorable determination examples:

Example A: Mr. Smith was disenrolled on June 30, 2015 following proper notice. 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 period of time prior to disenrollment. 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 prior to disenrollment. 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 period of time prior to disenrollment; 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 prior to disenrollment. Mr. Smith may not be reinstated for good cause.

Example B: Mr. Jones was disenrolled on May 31, 2015 following proper notice. 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 prior to disenrollment. 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 prior to disenrollment. Mr. Jones may not be reinstated for good cause.

Example C: Ms. Ferrera was disenrolled on March 31, 2015 following proper notice. 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 prior to disenrollment. Ms. Ferrera may not be reinstated for good cause.

Example D: Mr. Davis was disenrolled on July 31, 2015 following proper notice. 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. 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, 2015 following proper notice. 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 making timely payment; and 3) It is reasonable to expect that Ms. Adams could have paid or made arrangements to pay the owed amounts prior to disenrollment. Ms. Adams may not be reinstated for good cause.

Example F: Mrs. Johnson was disenrolled on March 31, 2015 following proper notice. 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 2015 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 period of time prior to disenrollment significant enough to cause 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 period of time prior to disenrollment; 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 prior to her disenrollment. Mrs. Johnson may not be reinstated for good cause.

Example G: Mr. Patel was disenrolled on September 30, 2015 following proper notice. 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 of personal financial issues he provided is listed specifically as the basis for an unfavorable determination; and 2) It is reasonable to expect Mr. Patel to have paid or made arrangements to pay the owed amounts prior to disenrollment. Mr. Patel may not be reinstated for good cause.

Example H: Ms. Ulman was disenrolled on June 30, 2015 following proper notice. She states that she needs to refill her medications and that she paid her owed amounts to the plan on July 20, 2015, following her disenrollment effective date. The plan issues an unfavorable good cause determination

because Ms. Ulman's need for medications was not a factor adversely affecting 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 prior to disenrollment. Ms. Ulman may not be reinstated for good cause.

Example I: Ms. Taylor was disenrolled on March 31, 2015 following proper notice. 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 prior to disenrollment. Ms. Taylor may not be reinstated for good cause.

Exhibit 1: Model Cost Plan Enrollment Form

(Rev. 2, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

[Organizations may include the image of the Medicare card in enrollment mechanisms.]

To Enroll in <name of plan>, Please Provide the Following Information:			
<p>[Optional Field Please check which plan you want to enroll in: _____ Product ABC \$XX per month* _____ Product XYZ \$XX per month*] *You must continue to pay your Part B premiums</p>			
Please indicate your requested enrollment effective date: _____			
LAST name:	FIRST Name:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (____/____/____) (M M /D D/ Y Y Y Y)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Phone Number: ()	
Permanent Residence Street Address:			
City:	State:	[Optional: County:]	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:
[Optional field: Emergency contact: _____]			
[Optional field: Phone Number: _____]			
[Optional field: Relationship to You _____]			
[Optional field E-mail Address: _____]			
Please Provide Your Medicare Insurance Information			
Please take out your red, white and blue Medicare card to complete this section. <ul style="list-style-type: none"> Fill out this information as it appears on your Medicare card - OR - Attach a copy of your Medicare card or your letter from the Social Security or the Railroad Retirement Board. 		Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is Entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part B to join a Medicare cost plan.	

[Optional: (this section applies only to cost plans offering an optional supplemental Part D benefit)]:

Your Plan Premium Payment Options

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

[Optional; 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.socialsecurity.gov/prescriptionhelp.]

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

[Include other optional methods, such as EFT & credit card as follows:

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

Account holder name: _____

Bank routing number: _____ Bank account number: _____

Account type: Checking Saving

- Credit Card. Please provide the following information:

Type of Card: _____

Name of Account holder as it appears on card: _____

Account number:

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

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

I get monthly benefits from: Social Security RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will not include all premiums due from your enrollment effective date up to the point withholding begins. We

will [insert one of the following or similar billing language: send you a paper bill/send you a coupon book] for those months before deduction from your Social Security/RRB check starts. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? Yes No

If you answered “yes” to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

2. Do you or your spouse work? Yes No

Do you have health coverage through you or your spouse's current or former employer? Yes No

If “yes,” please provide the following information:

Employer Name: _____ Employer Address: _____
Policy Holder Name: _____ Policy Number: _____

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

If yes, please provide your Medicaid number: _____

[Cost plans offering an optional supplemental Part D benefit must include:

4. Some individuals may have other drug coverage, including other private insurance such as through an employer or spouse’s employer, TRICARE, Federal Employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Do you or will you have other prescription drug coverage in addition to <plan name>? Yes No

If “yes,” please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____]

[Optional field **Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):**]

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

____ <include list of available languages>

____ <include list of accessible formats (like Braille, audio tape, or large print) >

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

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

[This box required only for cost plans offering an optional supplemental Part D benefit:]



Please Read This Important Information

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

Please Read and Sign Below

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

<Cost Plan Name> is a Medicare health plan and I will need to keep my Medicare Part B. I can be in only one Medicare Health plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I know I may disenroll from this plan at any time by sending a written request to <Cost Plan Name> or by calling 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

<Cost Plan Name> serves a specific service area. If I move out of the area that <Cost Plan Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Cost Plan Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of coverage document] from [name] when I receive it to know which rules I must follow in order to receive coverage with this Medicare health plan.

I understand that beginning on the date [name of plan] coverage starts, in order for [Cost Plan Name] to fully cover my medical services (except for emergency or urgently-needed services), all of my health care must be provided or arranged by [name of plan]. If obtain services not provided or arranged by the plan, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. *[If offering an optional supplemental Part D benefit include: I also acknowledge that <Cost 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 my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <Cost Plan Name> or by Medicare.

Your Signature:

Today's Date:

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

Name: _____

Address: _____

Phone Number: (____) ____-_____

Relationship to Enrollee _____

Office Use Only:

Name of staff member (if assisted in enrollment): _____

Plan ID #: _____

[Enrollment Period when applicable] IEP: _____ AEP: _____ SEP (type): _____

[optional space for other administrative information needed by plan]

<Federal Contracting Statement>

Exhibit 2: Model Notice to Acknowledge Receipt of Completed Enrollment Request

Referenced in section(s): 40.4, 40.4.1

[Member ID #]

[Cost plans offering Optional Supplement Part D Benefit must include: [Rx ID], [Rx Group], [Rx Bin], [Rx PCN]]

Dear <Name of member>:

Thank you for requesting to enroll in <Plan name>. Starting <effective date>, you must see your <Plan> doctor(s) for your health care in order for the plan to fully cover your medical services. You may obtain medical services not provided or arranged by [name of plan/organization], but you will be responsible for payment of all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. [Optional: As of <effective date>, you should begin using <Plan> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <Plan name> may not pay for your prescriptions.] [Optional language: **This letter can serve as evidence of insurance until you receive your membership card from us. You should show this letter to your doctor when you go to your doctor appointments until you receive your membership card.**]

All enrollment requests must be reviewed by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program. We will send your enrollment form to CMS, and a final review will be performed. When CMS finishes its review, we will send you a letter to confirm your enrollment with <Plan>. However, you can begin using <Plan> doctors [Optional: and network pharmacies] prior to receiving the confirmation letter. You should begin using <Plan> doctors [Optional: and network pharmacies] on <effective date>. Also, you should not cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the letter.

You must have Medicare Part B (Medical Insurance) to be a member of <name of plan>. If you do not have Medicare Part B, we will bill you for any health care you receive from us, and neither Medicare nor <name of plan> will pay for those services. Also, if you have End Stage Renal Disease (ESRD), you may not be able to enroll in <Plan>, and you may be billed for Medicare deductibles and coinsurance for any health care you received.

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.socialsecurity.gov/prescriptionhelp.

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.

<Federal Contracting Statement>

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

Exhibit 3: Model Notice to Request Information

Referenced in sections: 40.2.2, 40.4

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of beneficiary>:

Thank you for your application to <Plan name>. We cannot process your application until we receive one or more of the following things from you (please see item checked below):

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

- Logging into your MySocialSecurity.gov 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).

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

_____ Other: _____.

You will need to send this information to <Plan and address> by <date -30 days from date letter provided to the beneficiary>. If you cannot send this information by <date listed above>, we will have to deny your request to enroll in our plan. However, if you wish to apply at a later date, you may complete another application and provide the information necessary to process your request.

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.

<Federal Contracting Statement>

Exhibit 4: Model Notice to Confirm Enrollment

Referenced in sections: 40.4, 40.4.1

[Member ID #]

[Cost plans offering Optional Supplement Part D Benefit must include: <Rx ID>, <Rx Group>, <Rx Bin>, <Rx PCN>]

Dear <Name of Member>:

This letter is to tell you that the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, has approved your enrollment in <Plan>, beginning <effective date>.

[Optional: As of <effective date>, you should begin using <Plan> network pharmacies to fill your prescriptions. If you use an out-of-network pharmacy and there is not an emergency, <Plan name> may not pay for your prescriptions.] You must see your <Plan> doctor(s) for your health care in order for the plan to fully cover your medical services. If you obtain medical care from a non-network provider, you will be responsible for deductibles, coinsurance, or charges for services not covered by Medicare.

As we explained in an earlier letter, you may cancel any Medigap or supplemental insurance that you have now that we have confirmed your enrollment. Before canceling any supplemental insurance, be sure to determine if it is more beneficial to keep additional coverage.

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.sociaisecurity.gov/prescriptionhelp.

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

<Federal Contracting Statement>

Exhibit 5: Model Notice for Denial of Enrollment

Referenced in sections: 40.4, 40.5

Dear <Name of beneficiary>:

Thank you for applying for membership in <Plan>. We cannot accept your application for enrollment in <Plan> because:

1. ____ You do not have Medicare Part B
2. ____ You are unlawfully present in the United States.
3. ____ You have End Stage Renal Disease (ESRD).
4. ____ Your permanent residence is outside of our service area.
5. ____ You are incarcerated and currently reside outside of our service area.
6. ____ We did not receive the information we requested from you within 30 days of our request.

If any of the above items are checked, and our information is correct, then you may be billed for any services you received.

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

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

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.socialsecurity.gov/prescriptionhelp.

Thank you.

<Federal Contracting Statement>

Exhibit 5a: Model Notice for Denial of Enrollment in Optional Supplemental Part D Benefit

Referenced in section: 40.5.1

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of beneficiary>:

Thank you for selecting <name of Cost Plan drug benefit option>. We cannot accept your request for this Medicare prescription drug benefit because you attempted to enroll in it outside of an enrollment period or don't qualify for an enrollment period at this time.

You may enroll in or disenroll from Medicare prescription drug coverage only at certain times of the year. Generally, unless you meet certain special circumstances, such as if you move out of a plan service area, you may only make Medicare prescription drug plan choices between October 15 and December 7 of each year.

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.socialsecurity.gov/prescriptionhelp.

If you believe our information is incorrect, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

<Federal Contracting Statement>

Exhibit 6: Model Notice to Send Out Disenrollment Request

Referenced in section: 50.1

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of member>:

Attached is the disenrollment form you requested. Please complete the entire form, sign it, and return it to us in the enclosed envelope, or mail it to your local Social Security Office or Railroad Retirement Board Office. You can also fax it to us, as long as the signature and date are readable. Our fax number is <fax number>. You can also disenroll by calling 1-800-MEDICARE (1-800-633-4227) TTY users can call 1-877-486-2048.

If you are joining another Medicare Advantage or Medicare health plan, it is not necessary for you to complete the enclosed disenrollment form. You will be automatically disenrolled from <name of plan> if you submit an enrollment application for a new Medicare plan. However, please note that you can generally only choose other Medicare health plans, including drug plans, at certain times of the 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.

[Cost plans offering an optional supplemental Part D benefit must include]:

If you have selected to have Medicare prescription drug coverage from (name of plan), by disenrolling from (name of plan) you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about Medicare drug plans available in your area 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.

We will mail a copy of the disenrollment form back to you with the date of your disenrollment written on the form.

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

Thank you.

Attachment

<Federal Contracting Statement>

Exhibit 6a: Model Disenrollment Request

Referenced in section: 50.1

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

DATE _____

(Please Print in Ink)

MEMBER'S NAME _____
First Middle Last

ADDRESS _____
City State Zip Code County

TELEPHONE () _____

MALE _____ FEMALE _____ DATE OF BIRTH _____

MEDICARE NUMBER _____ [May use 'CURRENT MEMBER NUMBER'
in place of 'MEDICARE NUMBER']

DISENROLLMENT RESPONSIBILITIES:

Please carefully read and complete the following information before signing and dating this disenrollment form:

Note: If you want to return to Original Medicare (also known as the Medicare fee-for-service program), then you must complete this disenrollment form. We will notify you of the effective date of your disenrollment after we have received this form from you.

If you want to join another Medicare Advantage or Medicare health plan immediately following termination from <Health Plan name>, then you do **not** need to complete this form. Once you enroll in another Medicare plan, your current membership in <health plan name> will automatically be cancelled. However, please note that you can generally only choose other plans at certain times of the year.

[Cost plans offering an optional supplemental Part D benefit must include:

If you have selected to have Medicare prescription drug coverage from <name of plan>, by disenrolling from <name of plan> you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area 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.]

Disenrollment from the <health plan> will be effective on the first day of the month after the month <health plan> receives the written request (unless you request a later date of disenrollment). For example, if you complete this form and submit it to <health plan> on April 30, the last day of the month, your disenrollment will be effective the next day, May 1st. If you are requesting a later date, disenrollment cannot take place later than the third month after which you submit a completed

disenrollment request to <health plan>. Therefore, if you submit this form on April 30, the latest disenrollment date possible would be July 1.

Requested disenrollment date: _____

Your Signature

Date

<Federal Contracting Statement>

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

Exhibit 7: Model Notice to Acknowledge Receipt of Member's Voluntary Disenrollment Request

Referenced in section: 50.1.1

Dear <Name of beneficiary>:

We received your request to disenroll from <Health Plan Name> and you will be disenrolled effective <date.> Beginning <effective date>, <Health Plan Name> will not cover any health care you receive. A copy of your disenrollment request is enclosed.

[Cost plans offering an optional supplemental Part D benefit must include:

If you have selected to have Medicare prescription drug coverage from <name of plan>, by disenrolling from <name of plan> you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area 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.]

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.socialsecurity.gov/prescriptionhelp.

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

Enclosure

<Federal Contracting Statement>

Exhibit 8: Model Notice to Confirm Voluntary Disenrollment Identified Through Reply Listing

Referenced in section: 50.1.1

Dear <Name of beneficiary>: This is to confirm your disenrollment from <Health Plan>. This disenrollment began <effective date>, and <Health Plan> will not cover any health care you receive after that date. Please note that you may want to tell your doctors that if they need to send Medicare claims, you just disenrolled from <Health Plan> and there may be a short delay in having your records updated.

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 1-800325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you think you did not disenroll from <Health Plan>, and you want to remain a member of our plan, please call us right away at <phone number> <days and hours of operation>. TTY users should call <TTY number>.

Thank you.

<Federal Contracting Statement>

Exhibit 8a: Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan

Referenced in section: 50.1.1

IMPORTANT INFORMATION ABOUT YOUR UPCOMING DISENROLLMENT FROM YOUR MEDICARE HEALTH 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 <cost plan name>. You will continue to get your Medicare benefits from <cost plan name> until <disenrollment effective date>. Beginning <day following disenrollment effective date>, your new plan will cover your health care.

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

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

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

Thank you.

Exhibit 9: Model Notice of Disenrollment Due to Death

Referenced in section: 50.2.2

Note: Address letter To the Estate of <Member's Name> or To <Member's Name>

The Centers for Medicare & Medicaid Services, the federal agency that administers the Medicare program, has notified us of the death of <Member's Name>. Please accept our condolences. <Member's name>'s coverage in <name of health plan> has ended as of <effective date>. If membership premiums were paid for any month after <effective date>, we will refund the Estate within 30 days of this letter.

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

Thank you.

<Federal Contracting Statement>

Exhibit 10: Model Notice of Disenrollment Due to Loss of Medicare Part B

Referenced in section: 50.2.3

Dear <Member's Name>:

The Centers for Medicare & Medicaid Services, the federal agency that administers the Medicare program, has notified us that your Medicare Part B coverage has ended. Without Medicare Part B enrollment, you cannot continue your membership in <name of plan health plan>. Therefore, your coverage in <name of health plan> has ended as of <effective date>. If you paid plan premiums for any month after <effective date>, we will send you a refund within 30 days of this letter.

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

Thank you.

<Federal Contracting Statement>

Exhibit 11: [*Moved to Appendix 2*]

Exhibit 12: Model for Closing Enrollment

Referenced in sections: 30.1, 30.1.4

Model A: Closing Enrollment for Partial Month(s)

<PLAN NAME> PUBLIC NOTICE

As of [insert date] [health plan] will no longer offer continuous open enrollment under its contract with the Centers for Medicare & Medicaid Services for <plan name> in [insert service area].

Instead, <plan name> will offer open enrollment for all eligible individuals from the [insert date] to the [insert date] of each month.

Current members of <plan name> are not affected by this change. For information regarding this notice, call <plan name> at [insert phone number]. TTY users should call [insert number]. We are open [insert days and hours of operation].

Model B: Closing Enrollment for Whole Month(s)

<PLAN NAME> PUBLIC NOTICE

As of [insert date] <plan name> will no longer offer open enrollment under its contract with the Centers for Medicare & Medicaid Services [insert plan name] in [insert service area].

Current members of [insert name of plan] are not affected by this change. For information regarding this notice, call [insert name of organization] at [insert phone number]. TTY users should call [insert number]. We are open [insert days and hours of operation].

Model C: Closing Enrollment for Capacity Reasons

<PLAN NAME> PUBLIC NOTICE

As of [insert date], [insert name of health plan] will no longer accept enrollment under its contract with the Centers for Medicare & Medicaid Services [insert plan name] in [insert service area].

<Plan name> has been approved for a capacity limit by the Centers for Medicare & Medicaid Services. A capacity limit allows a health plan to limit enrollment once a specific number of members joins the plan. This is based in part on the accessibility and availability of providers to provide services to members of the plan.

Current members of <plan name> are not affected by this change. For information regarding this notice, call <plan name> at [insert phone number]. TTY users should call [insert number]. We are open [insert days and hours of operation].

<Federal Contracting Statement>

Exhibit 13: Model Notice to Inform Full Benefit Dual Eligible Member of Auto-Enrollment

Referenced in section: 40.1.5

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

Dear <insert member name>

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

Important: If you (or anyone on your behalf) have filled a prescription before <auto-enrollment effective date>, you may be eligible for reimbursement for some of these costs. Please contact Medicare's Limited Income Newly Eligible Transition (LI NET) Program at 1-800-783-1307 (TTY: 711) or visit www.humana.com/pharmacists/ on the web for more information.

This means that starting <effective date> you must see your <Plan> doctor(s) for your health care in order for the plan to fully cover your medical services. You may obtain medical services not provided or arranged by [name of plan/organization], but you will be responsible for payment of all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. [Optional language: This letter is proof of insurance that you should show during your doctor appointments.]

With the addition of this Medicare prescription drug coverage, you will pay:

- \$0 for your yearly prescription drug plan deductible,
- [insert appropriate LIS copay amount] copayments when you fill a prescription.

[Include cost of premium less low-income premium subsidy amount, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.

Remember, Medicaid will not pay for your prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover those prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <plan name>.

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in <name of cost plan without Medicare prescription drug coverage>, read all the materials you get from

your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, or the Department of Veterans Affairs. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in <name of cost plan without Medicare prescription drug coverage>. If you don't want Medicare prescription drug coverage, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

<Federal Contracting Statement>

Exhibit 13a: Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP

Referenced in section: 40.1.5

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

Dear < member name >

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

Important: If you (or anyone on your behalf) have filled a prescription before <auto-enrollment effective date>, you may be eligible for reimbursement for some of these costs. Please contact Medicare's Limited Income Newly Eligible Transition (LI NET) Program at 1-800-783-1307 (TTY: 711) or visit www.humana.com/pharmacists/ on the web for more information.

This means that starting <effective date>, all of your health care, will continue to be covered under your <current cost plan>, and your pharmacy coverage will be provided through our <PDP> plan. Your medical benefits and member copayments under <current cost plan> will not change. *[Optional language: You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]*

With the addition of this Medicare prescription drug coverage, you will pay:

- \$0 for your yearly prescription drug plan deductible,
- *[insert appropriate LIS copay amount]* copayments when you fill a prescription.

There will be no changes to your premium, medical benefits or member copayments under the <name of cost plan without Medicare prescription drug coverage>.

Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <plan name>.

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in <name of cost plan without Medicare prescription drug coverage>, read all the materials you get from

your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, or the Department of Veterans Affairs. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in <name of cost plan without Medicare prescription drug coverage>. If you don't want Medicare prescription drug coverage, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

<Federal Contracting Statement>

Exhibit 14: Model Notice to Inform Member of Facilitated Enrollment

Referenced in section: 40.1.5

[Member#]

[RxID]

[RxGroup]

[RxBin]

[RxPCN]

Dear <insert member name>

Our records show that you qualify for extra help with your prescription drug costs. Medicare has asked us to enroll you in our <name of cost plan> that offers Medicare prescription drug coverage, beginning <effective date>. This way, you will pay the lowest possible premium for Medicare prescription drug coverage.

With the addition of this Medicare prescription drug coverage, you will pay:

- [*insert appropriate LIS deductible amount*] for your yearly prescription drug plan deductible,
- [*insert appropriate LIS copay amount*] copayments when you fill a prescription.

[Include cost of premium less amount of premium assistance the member is eligible for, brief description of benefit, emergency room, durable medical equipment, inpatient care, annual out of pocket maximum on coinsurance services, etc. if changes. If no changes, simply state that there will be no changes.]

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in <name of cost plan without Medicare prescription drug coverage>, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, or the Department of Veterans Affairs. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in <name of cost plan without Medicare prescription drug coverage>. If you don't want Medicare prescription drug coverage, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

<Federal Contracting Statement>

Exhibit 14a: Model Notice to Inform Other LIS Eligible Member of Auto-Enrollment in PDP

Referenced in section: 40.1.5

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

Dear <insert member name>

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

This means that starting <effective date>, all of your health care, will continue to be covered under <name of cost plan without Medicare prescription drug coverage>, and your pharmacy coverage will be provided through our <PDP> plan. Your medical benefits and member copayments under <name of cost plan without Medicare prescription drug coverage> will not change. *[Optional language: You will be sent a pharmacy card along with more detailed information about your pharmacy coverage in the next several days. Until you receive your pharmacy card, you can use this letter to purchase your prescriptions. This letter includes the information needed to obtain your prescriptions.]*

With the addition of this Medicare prescription drug coverage, you will pay:

- \$0 for your yearly prescription drug plan deductible,
- *[insert appropriate LIS copay amount]* copayments when you fill a prescription.

There will be no changes to your premium, medical benefits or member copayments under the <name of cost plan without Medicare prescription drug coverage>.

Remember, Medicaid will not pay for most prescription drugs. Federal law will not let Medicaid continue the drug coverage you currently get. Some state Medicaid programs may cover a few prescriptions that won't be covered under Medicare prescription drug coverage. This coverage alone won't be at least as good as Medicare prescription drug coverage. To continue to have prescription drug coverage, you must be enrolled in a Medicare prescription drug plan, like <PDP name>.

If you have other types of prescription drug coverage, or if your employer pays for your enrollment in <name of cost plan without Medicare prescription drug coverage>, read all the materials you get from your insurer or plan provider. Examples of other types of prescription drug coverage include coverage from an employer or union, TRICARE, or the Department of Veterans Affairs. Talk to your benefits administrator, insurer, or plan provider. Ask them if enrolling in Medicare drug coverage would hurt your other benefits.

You are not required to be in our Medicare prescription drug plan and have the option to stay in <name of cost plan without Medicare prescription drug coverage>. If you don't want Medicare prescription drug coverage, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You will need to tell us if you don't want Medicare prescription drug coverage.

Thank you.

<Federal Contracting Statement>

Exhibit 15: Acknowledgement of Request to Decline Part D

Referenced in section: 40.1.5

Dear <name of member>:

As requested, we have processed your request to decline Medicare prescription drug coverage. You will continue to be a member of <cost plan without Medicare prescription drug coverage> that does not offer Medicare prescription drug coverage.

If you had Medicaid drug coverage, it will no longer pay for your prescription drugs. Our records show you are eligible for extra help with your prescription drug costs, but you must have Medicare prescription drug coverage to get this help.

Remember, even if you don't use a lot of prescription drugs now, you still should consider signing up for a Medicare prescription drug plan. For most people, joining now means you will pay your lowest possible monthly premium. If you don't join a prescription drug plan when you are first eligible for one, and you don't currently have prescription drug coverage that covers at least as much as Medicare prescription drug coverage, your premium cost may go up at least 1% per month for every month that you wait to enroll. You will have to pay this penalty as long as you have Medicare prescription drug coverage.

If you change your mind now or at any time in the future, or if you have any questions, please contact customer service at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

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.socialsecurity.gov/prescriptionhelp.

Thank you.

<Federal Contracting Statement>

Exhibit 16: Model Confirmation of Reinstatement

Referenced in sections: 60.6, 60.6.1, 60.6.2, 60.6.3

Dear <member name>

Please be sure to keep this letter for your records.

Medicare has enrolled you back in <plan name> as of <effective date>.

You should keep using your <plan name> providers for your health care. [If member is also enrolled in the optional supplemental Part D benefit, insert “and <plan name> network pharmacies to fill your prescriptions” at the end of the prior sentence.]

[Insert one of the following depending on plan policy: We will send you a new membership card and other important documents for <plan name>. or You can continue to use 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 phone number>. We are open <days and hours of operation>.

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

<Federal Contracting Statement>

Exhibit 17: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status

Referenced in sections: 60.6, 60.6.1

Dear< Name of Member>:

Medicare records incorrectly show you as deceased.

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

In the meantime, you should keep using your <plan name> providers for your health care. [If member is also enrolled in the optional supplemental Part D benefit, insert "and <plan name> network pharmacies to fill your prescriptions" at the end of the prior sentence.

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

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

<Federal Contracting Statement>

Exhibit 18: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part B Termination

Referenced in sections: 60.6, 60.6.1

Dear < Name of Member >:

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

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

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

1. Contact Social Security at 1-800-772-1213 between 7AM to 7PM, Monday to Friday, to have them fix their records. TTY users should call 1-800-325-0778.
2. Ask Social Security to give you a letter that says they have fixed your records.
3. Send the letter from Social Security to us at: <plan address> in the enclosed postage-paid envelope. You may also fax this information to us at <fax number>. When we get this letter, we will tell the Medicare to correct its records.]

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

In the meantime, you should keep using your <plan name> providers for your health care. [If member is also enrolled in the optional supplemental Part D benefit, insert “and <plan name> network pharmacies to fill your prescriptions” at the end of the prior sentence.

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

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

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

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

<Federal Contracting Statement>

Exhibit 19: Notice of Failure to Pay Plan Premiums (or other charges) – Notification of Involuntary Disenrollment from Cost Plan Contract

Referenced in section: 50.3.1

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

Dear < Member>:

On <date of notification letter>, we sent you a bill for the <insert language regarding purpose for bill: premiums, coinsurance, deductible> you owe. Since we didn't get that payment, we have asked Medicare to disenroll you. Your disenrollment begins <effective date>. As of <effective date>, <plan name> won't cover your medical costs [*For cost plans with optional supplemental Part D benefits, insert:* or your prescription drug costs.] [Note: Cost plans that offer additional optional supplemental benefits, such as dental, may insert other benefits that the cost plan won't cover due to the involuntary disenrollment from the cost plan contract.]

This letter only applies to your benefits through <plan name>. Your other Medicare benefits aren't affected by your disenrollment from <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 amounts within 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>.

[Cost plans with optional supplemental Part D benefits, add the following four paragraphs:

When can I get Part D coverage?

You can change prescription drug plans only at certain times during the year. **From October 15 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 special situations, such as if you move out of your Part D 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 paying for prescription drug costs.

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

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 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 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.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this Extra Help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for Extra Help.]

For more information:

If you have recently sent us a payment, please call <plan name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

<Federal Contracting Statement>

Exhibit 19a: Notice of Failure to Pay Premiums – Notification of Loss of Optional Supplemental Part D Benefit

Referenced in section: 50.3.1

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

Dear < Member>:

On <date of notification letter>, we sent you a bill for the Part D benefit premiums you owe. Since we didn't get that payment, we have asked Medicare to disenroll you from the optional supplemental Part D benefit. Your disenrollment begins <effective date>. As of <effective date>, <plan name> won't cover your prescription drug costs.

This letter only applies to your prescription drug coverage. You will still have health coverage through <cost plan name>benefits through <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 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?

You can change prescription drug plans only at certain times during the year. **From October 15 December 7 each year**, you can join, switch, or drop a Medicare health or drug plan for the following year. Generally, you may you can't make changes at other times except in certain situations, such as if you move out of your Part D plan'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 drug costs.

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 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 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.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this Extra Help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for Extra Help.]

For more information:

If you have recently sent us a payment, please call <plan name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

<Federal Contracting Statement>

Exhibit 20: Notice of Confirmation of Involuntary Disenrollment from Cost Plan Contract for Failure to Pay Plan Premiums (or other charges)

Referenced in section: 50.3.1

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Beneficiary>:

Medicare has confirmed your disenrollment from <plan name> because you didn't pay your <insert reason for disenrollment, such as: premium, coinsurance, deductible>. Your disenrollment begins <effective date>. You are now in Original Medicare.

What if I think there's been a mistake?

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

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

You can ask us to review this decision if you had an emergency or unexpected situation that kept you from paying your premiums on time. If we approve your request, you will have to pay all owed amounts within 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>.

[Cost plans with optional supplemental Part D benefits, add the following four paragraphs:]

When can I get Part D coverage?

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

Please remember, if you 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 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 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.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this Extra Help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for Extra Help.]

For more information:

If you have recently sent us a payment, please call <plan name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Thank you.

<Federal Contracting Statement>

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

Referenced in section: 50.2.5

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Important – You have been disenrolled from your Cost Plan Prescription Drug Benefit

<Date>

Dear <Beneficiary Name>:

As of <disenrollment effective date>, Medicare has disenrolled you from <cost plan name's optional supplemental Part D benefit> 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 optional supplemental Part D benefit premium was paid for any month after <disenrollment effective date>, you'll get a refund from us within 30 days of this letter. The decision to disenroll you was made by Medicare, not by <plan name>.

What if I think there's been a mistake?

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

I had an emergency that kept me from sending my 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 owed Part D-IRMAA and plan premium amounts within 3 months of your disenrollment in order to get your coverage back. Call Medicare at 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week, 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 of your prescription drug coverage within 60 days and pay all owed amounts within 3 months, you will not get your coverage back and will have to wait for another opportunity to get Part D coverage. 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?

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

Medicare limits when you can make changes to your Part D 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 of the year except in certain situations, such as you move out of your Part D 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.

Who can I call to get more information?

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

Thank you.

<Federal Contracting Statement>

Exhibit 22: Model Notice on Favorable Good Cause Determination for Loss of Optional Supplemental Part D Benefit Due to Nonpayment of Part D-IRMAA – Notification of Premium Amount Due for Reinstatement

Referenced in section(s): 60.6.3

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

Medicare notified us that you received a favorable decision on your request for reinstatement of your <plan name> optional supplemental Part D benefit. Our records show that we haven't gotten payment for your <insert all that apply: plan premium, coinsurance, deductible, optional supplemental Part D benefit premium> as of <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 date optional supplemental Part D benefit ended>.

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 date optional supplemental Part D benefit ended> to be reinstated.

[Cost plans may elect to mail a payment coupon with the letter. Cost plans who include the 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.]

[Cost plans 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.]

[Cost plans that permit other types of payment such as EFT, or credit cards, insert other applicable information.]

If we don't get payment by <date 3 months from the date optional supplemental Part D benefit ended>, you will remain disenrolled from <plan name>'s optional supplemental benefit.

When can I get Part D coverage?

Remember, Medicare limits when you can make changes to your Part D 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 of the year except in certain situations, such as you move out of your Part D plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

Please remember, if you 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?

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

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.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this Extra Help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for Extra Help.

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

Thank you.

<Federal Contracting Statement>

Exhibit 22a: Model Notice on Favorable Good Cause Determination – Notification of Premium Amount Due for Reinstatement into Cost Plan Contract or Reinstatement of Optional Supplemental Part D Benefit

Referenced in section: 60.6.3

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Name of Member>:

We reviewed your request to get your coverage back and made a favorable decision regarding your request for reinstatement into <insert either: plan name, optional supplemental Part D benefit or plan's name with the optional supplemental Part D benefit>. Our records show that we haven't gotten payment for your plan <insert all that apply: premium, coinsurance, deductibles, optional supplemental Part D benefit> as of <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 or loss of the optional supplemental Part D benefit >**.

If we don't get payment by <date 3 months from the effective date of disenrollment or loss of the optional supplemental Part D benefit>, you will remain disenrolled from <insert as applicable: plan name, optional supplemental Part D benefit or plan name with optional supplemental Part D benefit>. [Insert one of the following: You will be covered by Original Medicare instead of <plan name>; You will be covered by Original Medicare instead of <plan name> and will not have prescription drug coverage; You will still have health coverage through <plan name> but you will not have prescription drug coverage.]

[Cost plans may elect to mail a payment coupon with the letter. Cost plans that include the 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.]

[Cost plans 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.]

[Cost plans that permit other types of payment such as EFT, or credit cards, insert other applicable information.]

When can I get Part D coverage?

Medicare limits when you can make changes to your Part D 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 of the year except in certain situations, such as you move out of your Part D 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.

[If the disenrollment from the cost plan contract also included the optional supplemental Part D benefit, insert: Please remember, if you don't have other creditable coverage (prescription drug coverage that is expected to pay on average as much as Medicare), you may have to pay a Part D late

enrollment penalty if you enroll in Medicare prescription drug coverage in the future.]

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 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.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this Extra Help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for Extra Help.

For more information:

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

Thank you.

<Federal Contracting Statement>

Exhibit 22b: Model Notice on Unfavorable Good Cause Determination for Disenrollment Due to Nonpayment of Plan Premiums (or other charges)

Referenced in section: 60.6.3

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

Dear <Beneficiary Name>:

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

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

When can I get Part D coverage?

Medicare limits when you can make changes to your Part D 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 of the year except in certain situations, such as you move out of your Part D plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

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

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 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 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.socialsecurity.gov/prescriptionhelp.

If you qualify for Extra Help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this Extra Help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for Extra Help.]

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:

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

Thank you.

Exhibit 22c: Model Notice to Close Out Good Cause Reinstatement Request – Failure to Pay Plan Premiums (or other charges) within 3 Months of Disenrollment

Referenced in section: 60.6.3

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

<Beneficiary full name>

<Address>

<City, State Zip>

Dear <Beneficiary Name>:

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

The letter told you that in order to be reinstated into <plan name>, you had to pay all plan premiums and other charges 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 from <insert as applicable: plan name; plan name and our optional supplemental Part D benefit>.

Your Payment Wasn't Received on Time

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

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

When can I get Part D coverage?

Medicare limits when you can make changes to your Part D 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 of the year except in certain situations, such as you move out of your Part D plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

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

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 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 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.socialsecurity.gov/prescriptionhelp.]

If you qualify for Extra Help with your prescription drug costs you may enroll in, or disenroll from, a plan at any time. If you lose this Extra Help during the year, your opportunity to make a change continues for two months after you are notified that you no longer qualify for Extra Help.]

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

Referenced in section(s): 60.6.3.1

<Member # >

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

Dear <Beneficiary Name>:

We reviewed your request to get your coverage back, and your request has been approved. Our records show that we received the *[Cost plans insert reason for disenrollment, such as: premium, coinsurance, deductible, Part D benefit 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 must see your <plan name> doctor(s) for your health care in order for the plan to fully cover your medical services. If you obtain medical care from a non-network provider, you will be responsible for deductibles, coinsurance, or charges for services not covered by Medicare. (Insert if applicable: You should continue to fill your prescriptions at <plan 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 23: Confirmation of Cancellation of Enrollment Due to Notice from CMS (TRC 015)

Referenced in section: 60.5.3

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

Dear <name of applicant>:

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

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

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.socialsecurity.gov/prescriptionhelp.

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

Referenced in section: 50.2.1

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<Date>

Dear <member 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>. [*Insert if member has Part D optional supplemental benefit: Your Medicare prescription drug coverage ended 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, not by <plan name>.

What if I think there's been a mistake?

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

What happens to my Medicare and Part D coverage?

While you are incarcerated, you are not eligible to enroll in a Medicare health or Part D plan. However, once you are released and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. *This opportunity begins the month you are released and lasts for two additional months.* If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. Generally, you can't make changes at other times of the year except in certain situations, such as you want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs.

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

Who can I call to get more information?

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

Thank you.

Exhibit 25: Notification of Involuntary Disenrollment by the Centers for Medicare & Medicaid Services due to Loss of Lawful Presence

Referenced in section: 50.2.6

(Rev. 1, Issued: July 31, 2018; Effective/Implementation: 01-01-2019)

<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>. [Insert if member has Part D optional supplemental benefit: Your Medicare prescription drug coverage ends on this date.] You will have Original Medicare; however, Medicare doesn't pay for your hospital or medical bills if you're not lawfully present in the U. S.

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

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

What if I think there's been a mistake?

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

What happens to my Medicare and Part D coverage?

While you are unlawfully present in the United States, you are not eligible to receive any coverage in the Medicare program. This includes coverage through Original Medicare, a Medicare health plan or Medicare prescription drug coverage. If you become lawfully present in the U.S. in the future and report it to SSA, you will have a special opportunity to join a Medicare health or Part D plan. This opportunity begins the month you regain lawful presence status and lasts for two additional months. If you don't enroll at that time, you can enroll in a new Medicare health plan or Medicare prescription drug plan from **October 15 through December 7 of each year** for coverage to start the following year. Generally, you can't make changes at other times of the year except in certain situations, 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 qualify for (or lose) Extra Help paying for prescription drug costs.

Please remember, if you go without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more after 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.