

**MODEL ANNUAL NOTICE OF CHANGE #1**

**(Renewing Plan-Sent to all members)**

**PDP only**

**[NOTE: This document must also be sent to all new members who enroll in a plan between October 31<sup>st</sup> and December 31<sup>st</sup>.]**

Dear <member name/Member>:

*[Note: The organization may modify this introductory paragraph to tailor to its needs, as long as the paragraph is kept brief.]* This is the time of year when we like to thank you for your membership in our plan. We want to take this opportunity to inform you of plan changes that will start on January 1, <year>. These changes are described in this letter:

- **How will my monthly premium change for <year>?**
- **How will my benefits and costs change for <year>?**
- **What if my drug is no longer on the formulary or is in a more expensive tier in <year>?**
- **What do I need to know if I qualify for extra help from Medicare to pay for my prescription drugs?**
- **What happens if I want to leave my plan?**

**How will my monthly premium change for <year>?**

Starting January 1, <year>, the monthly premium that you pay to <plan name> will [*<increase/decrease> from \$<xx.xx> to \$<yy.yy>*] [*stay the same at \$<xx.xx>*]. This amount does not include any late enrollment penalty you may be responsible for paying.

**How will my benefits and costs change for <year>?**

We have enclosed a <year> Summary of Benefits and a formulary that will be effective January 1, <year>. Medicare has reviewed and approved the benefits described in the Summary of Benefits and covered drugs listed in the formulary. We will send you [*If you are sending earlier than January 31, 2007, insert: "by <date>" Otherwise insert: "by January 31, 2007"*] an Evidence of Coverage which will explain in detail all of our plan rules and benefits that will be in effect as of January 1, <year>. All changes begin January 1, <year>, and will be in effect through December 31, <year> except for those formulary changes that decrease cost or increase safety. **Rest assured that you will be a member of <plan name> for the coming year if you do nothing to change your Medicare coverage.**

*[Plans that have changed one or more of the following must clearly describe or compare the changes from the current benefit year to the upcoming benefit year:*

- *Tier structure*
- *Types of drugs in each tier*
- *Cost sharing*

*Addition or removal of utilization management tools (prior authorization, step therapy, quantity limits, and mandatory generics).*

*This information may be clearer to beneficiaries in table format]*

We have also changed our formulary. We have added, removed or placed additional limitations on some of the drugs we cover. Please review the formulary to see if we still cover the drugs that you currently take. *[If including a complete formulary, use the following language: “The enclosed formulary can also be found on our <formulary web site> or you can call <customer/member> service if you need any assistance locating a particular drug.”]* *[If including an abridged formulary, use the following language: “To get a complete listing of all the drugs we cover, you can visit our <formulary web site> or call <customer/member> service.”]*

*[Plans not continuing approved exception requests into a subsequent plan year for renewing enrollees must add the following language if those enrollees are not otherwise notified in writing that the exceptions will not continue into the subsequent plan year: “If you received approval for a formulary or tiering exception request during the 2006 plan year, coverage for the drug approved under the exception will end on December 31, 2006.”]*

**What if my drug is no longer on the formulary or is in a more expensive tier in <year>?**

If we no longer cover your drugs or your drug has moved to a more expensive tier, you will need to talk with your doctor about appropriate alternative therapies available on our new formulary. *[If there are no appropriate alternative therapies on our formulary, you or your doctor can request a formulary or tiering exception by <insert date>. Refer to the enclosed <plan> formulary for exception filing instructions. If approved, we will start covering your drug starting on January 1<sup>st</sup>.]* *[Beginning January 1, you will get a temporary supply of the drug, but you will need to talk to your doctor about switching to a covered drug, or request a formulary exception if we no longer cover your drug(s).]*

**What do I need to know if I qualify for extra help from Medicare to pay for my prescription drug coverage?**

If you continue to qualify for the same amount of help next year, the table below tells you how your prescription costs will change:

<b>If you pay this much this year</b>	<b>You will pay this much next year</b>
\$0 deductible	\$0 deductible
\$50 deductible	\$53 deductible
\$1 for generics and brands that are treated as generics \$3 for brand name drugs	\$1 for generics and brands that are treated as generics \$3.10 for brand name drugs
\$2 for generics and brands that are treated as generics \$5 for brand name drugs	\$2.15 for generics and brands that are treated as generics \$5.35 for brand name drugs
15% co-insurance for all drugs	15% co-insurance for all drugs

If you qualify for extra help, you pay \$0 or a reduced monthly premium. If you continue to qualify for the same amount of help next year, the table below tells how much you will pay for a monthly premium. (This does not include any Medicare Part B premium you may have to pay.)

Your level of extra help	Monthly Premium for <Plan Name>
100%	\$<xx.xx>
75%	\$<xx.xx>
50%	\$<xx.xx>
25%	\$<xx.xx>

You may receive (or may have received) a letter from Medicare or the Social Security Administration (SSA) about your eligibility for extra help in 2007. Read this important information carefully. (If you don't know what level of extra help you qualify for, you can call 1-800-MEDICARE (1-800-633-4227) for this information. TTY/TDD users should call 1-877-486-2048. They are available 24 hours a day, 7 days a week.)

*[If plan qualified for auto-enrollment in 2006, but will not in 2007 because premium will exceed the region-specific low-income premium subsidy amount, insert the following language: " If you are also eligible for extra help, you might get a letter from Medicare offering to move you to a Medicare drug plan where you won't have to pay any monthly premium in 2007. Medicare will send these letters out by early November. If Medicare offers to move you to a different plan, but you want to stay with our plan, please contact us at <customer service number/hours>." ]*

*[As an enhanced benefit, <plan> offers additional coverage on some prescription drugs that are normally excluded from coverage. IF you receive extra help from Medicare in paying for your drugs, you will NOT receive this extra help for these particular drugs. Please refer to the enclosed formulary to see which drugs these are. Your co-pay/co-insurance amounts for these drugs are listed in the enclosed Summary of Benefits.]*

**What happens if I want to leave my current plan?**

*[In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information.]*

There are limits on when and how often you can change the way you get your Medicare prescription drug coverage and what choices are available to you when you make the change. You can change plans from November 15, <year> through December 31, <year> with coverage in your new plan beginning on January 1, <year>. To minimize the chance of any issues that may occur due to changing plans, it is better to not wait until December 31<sup>st</sup> to change plans, if you are going to make a change. This would include switching to another plan we offer or to a plan offered by a different organization. You can't make

any other changes during the year unless you meet special exceptions, such as if you move or if you have both Medicare and Medicaid coverage.

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

**For more information**

You can contact us if you need additional information, including

- How we manage the use of services and costs;
- The number of appeals and grievances filed by our members;
- A summary description of how we pay our pharmacies; and
- A description of our financial condition, including a summary of our most recent audit statement.

Please call our <Customer/Member> Services Department <days and hours of operation>, at <phone number> if you have any questions. TTY/TDD users should call <TTY/TDD phone number>.

We look forward to serving you now and in the future.

Sincerely,

<Plan Representative>

Encl: Summary of Benefits  
Formulary

<Material ID number>

<mm/yyyy>

**MODEL ANNUAL NOTICE OF CHANGE #2**

**(Members who will be rolled into another plan offered by same organization)  
PDP only**

**[NOTE: This document must also be sent to all new members who enroll in a plan between October 31<sup>st</sup> and December 31<sup>st</sup>.]**

Dear <member name/Member>:

*[Note: The organization may modify this introductory paragraph to tailor to its needs, as long as the paragraph is kept brief.]* This is the time of year when we like to thank you for your membership in our plan. We want to take this opportunity to inform you of our new plan name for the upcoming year. Beginning January 1, <year>, our new plan name will be <plan name>.

The following are described in this letter:

- **How will my monthly premium change for <year>?**
- **How will my benefits and costs change for <year>?**
- **What if my drug is no longer on the formulary or is in a more expensive tier in <year>?**
- **What important information changes should I expect, if I am receiving extra help from Medicare to pay for my prescription drugs?**
- **What happens if I want to leave my plan?**

**How will my monthly premium change for <year>?**

Starting January 1, <year> you will pay monthly premium of <\$xx.xx> to <plan name>. This amount does not include any late enrollment penalty you may be responsible for paying.

**How will my benefits and costs change for <year>?**

We have enclosed a <year> Summary of Benefits for <plan name> and a new formulary that will be effective January 1, <year>. Medicare has reviewed and approved the benefits described in the Summary of Benefits and covered drugs listed in the formulary. All changes begin January 1, <year>, and will be in effect through December 31, <year>, except for those formulary changes that decrease cost or increase safety. We will send you *[If you are sending earlier than January 31, 2007, insert: "by <date>" Otherwise insert: "by January 31, 2007"* an Evidence of Coverage which will explain in detail all of our plan rules and benefits that will be in effect as of January 1, <year>. **Rest assured that you will be a member of <plan name 2> for the coming year if you do nothing to change your Medicare coverage.**

*[Plans that have changed one or more of the following must clearly describe/compare the changes from the current benefit package to the new benefit package:*

- *Tier structure*
- *Types of drugs in each tier*

- *Cost sharing, including premium*
- *Addition or removal of utilization management tools (prior authorization, step therapy, quantity limits, and mandatory generics)*

*This information may be clearer to beneficiaries in a table format.]*

The formulary for <plan name> may be different than the one you are using. We have added, removed or placed additional limitations on some of the drugs we cover. Please review the formulary to see if we still cover the drugs that you currently take. *[If including a complete formulary, use the following language: "The enclosed formulary can also be found on our <formulary web site> or you can call <customer/member> service if you need any assistance locating a particular drug."]* *[If including an abridged formulary, use the following language: "To get a complete listing of all the drugs we cover, you can visit our <formulary web site> or call <customer/member> service."]*

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**What if my drug is no longer on the formulary or is in a more expensive tier in <year>?**

If we no longer cover your drugs or your drug has moved to a more expensive tier, you will need to talk with your doctor about appropriate alternative therapies available on our new formulary. *[If there are no appropriate alternative therapies on our formulary, you or your doctor can request a formulary or tiering exception by <insert date>. Refer to the enclosed <plan> formulary for exception filing instructions. If approved, we will start covering your drug starting on January 1<sup>st</sup>.]* *[Beginning January 1, you will get a temporary supply of the drug, but you will need to talk to your doctor about switching to a covered drug, or request a formulary exception if we no longer cover your drug(s).]*

**What do I need to know if I qualify for extra help from Medicare to pay for my prescription drugs?**

If you continue to qualify for the same amount of help next year, the table below tells you how your prescription costs will change:

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15% co-insurance for all drugs	15% co-insurance for all drugs
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If you qualify for extra help, you pay \$0 or a reduced monthly premium. If you continue to qualify for the same amount of help next year, the table below tells how much you will pay for a monthly premium. (This does not include any Medicare Part B premium you may have to pay.)

Your level of extra help	Monthly Premium for <Plan Name>
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50%	\$<xx.xx>
25%	\$<xx.xx>

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*[As an enhanced benefit, <plan> offers additional coverage on some prescription drugs that are normally excluded from coverage. IF you receive extra help from Medicare in paying for your drugs, you will NOT receive this extra help for these particular drugs. Please refer to the enclosed formulary to see which drugs these are. Your co-payment/co-insurance amounts for these drugs are listed in the enclosed Summary of Benefits.]*

**What happens if I want to leave my current plan?**

*[In addition, if the organization lists only one plan in the SB but offers multiple plans in the service area, the ANOC must notify beneficiaries that additional plans are available and include specific information on how beneficiaries can obtain more information.]*

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any other changes during the year unless you meet special exceptions, such as if you move or if you have both Medicare and Medicaid coverage.

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

**For more information**

You can contact us if you need additional information, including

- How we manage the use of services and costs;
- The number of appeals and grievances filed by our members;
- A summary description of how we pay our pharmacies; and
- A description of our financial condition, including a summary of our most recent audit statement.

Please call our <Customer/Member> Services Department <days and hours of operation>, at <phone number> if you have any questions. TTY/TDD users should call <TTY/TDD phone number>.

We look forward to serving you now and in the future.

Sincerely,  
<Plan Representative>

Encl: Summary of Benefits  
Formulary

<Material ID number>  
<mm/yyyy>