

[SURVEY VENDOR LOGO] and/or [QHP ISSUER LOGO ONLY NO ADDRESS]  
[SURVEY VENDOR ADDRESS]

OMB No. 0938-1221: Approval Expires XX/XX/20XX

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[FIRST AND LAST NAME]  
[LINE ONE OF ADDRESS]  
[LINE TWO OF ADDRESS (IF ANY)]  
[CITY, STATE ZIP]

Dear [ENROLLEE FIRST AND LAST NAME],

**We need your help.** Recently, we mailed you a survey as part of a national ongoing effort to evaluate the experiences you had with your health plan. The results will help consumers like you make important choices about their health care and will help health plans improve the care they provide. If you feel this survey does not apply to you, or if you have any questions, please call [SURVEY VENDOR NAME] toll free at (XXX) [XXX-XXXX] between [XX:XX] a.m. and [XX:XX] p.m. [SURVEY VENDOR LOCAL TIME], Monday through Friday (excluding federal holidays), or e-mail [SURVEY VENDOR E-MAIL].

We have enclosed another copy of the survey. Please take the time to tell us what you think about the care you received from your health plan in the last 6 months. Please return the completed survey in the enclosed pre-paid envelope. This is your chance to help your health plan serve you better.

[QHP ISSUER NAME] contracted with [SURVEY VENDOR NAME] to conduct this survey. You have been chosen as part of a random sample of enrollees in your health plan. Your answers are important and we cannot replace you with anyone else. If you changed your health plan for 2018, please answer the questions in the survey based on your experience with the health plan you had from July through December 2017. The survey will take about 15 minutes to complete.

Your answers will be part of a pool of information from others who are enrolled in your health plan. The information you provide will only be shared with authorized persons. Your health plan will not see your responses. **You may choose to fill out this survey or not. If you choose not to, this will not affect the benefits you receive.** However, your knowledge and experiences will help other people like you choose a health plan, so we hope you will help us.

Si prefieres la encuesta en español, por favor llame al (XXX) [XXX-XXXX].

[IF OFFERING CHINESE] □□□□□□□□□□□□ (XXX) [XXX-XXXX].

Sincerely,

[SIGNATURE]

[NAME & TITLE OF SENIOR EXECUTIVE  
FROM SURVEY VENDOR or QHP ISSUER]

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1221. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.