MVP HEALTH CARE

MVP Medicare Advantage Health Plans

Employer Handbook

MVP HEALTH CARE

MVP Health Care® is dedicated to healthier living for your retirees **and** making it easy for you to work with us.

Having up-to-date and accurate information makes managing your retiree benefits simpler.

This handbook includes the latest information to help you manage your MVP Medicare Advantage health plans. In it you'll find information on:

- **Medicare**
- **Eligibility requirements for Medicare and MVP Medicare Advantage plans**
- **The enrollment and billing processes**
- **Answers to commonly asked questions**

The ABCs and Part D of Medicare

Medicare Eligibility

A person who is eligible for Social Security will become eligible for Medicare:

- At age 65, or by virtue of a disability as defined by Social Security
- If they worked at least 10 years in Medicare-covered employment
- If they are a U.S. citizen/permanent U.S. resident
- Due to End Stage Renal Disease (ESRD)

Medicare Part A

Part A helps cover hospital inpatient care and skilled nursing facilities (not custodial or long term care). It also helps cover hospice and home health care. Most people receive Part A automatically when they turn age 65 and pay no monthly premium. This is because they or a spouse paid Medicare taxes while working.

If individuals do not automatically receive premium-free Part A, they may be able to purchase it if:

- They or their spouse aren't entitled to Social Security because they did not work or did not pay enough Medicare taxes while working, and they are age 65 or older
- They are disabled but no longer receive premium-free Part A because they returned to work

Medicare Part B

Part B covers medical and doctor services, outpatient hospital care, and other services. The member pays an annual deductible and 20% co-insurance. Members continue to pay the Part B premium monthly out of their Social Security check. Members enrolled in Medicare Part B not currently collecting Social Security will be billed quarterly by Social Security for their Part B premium.

If a person declines Part B when first eligible, the cost of enrolling in Part B at a later date may be increased by 10% for each full 12-month period that they should have had Part B. The Part B penalty can be waived if a person is still actively employed, or their spouse is actively employed and the person has health insurance coverage under an employer/union group health care plan (the employer must have more than 20 employees).

Under Part B, if a person did not sign up when first eligible because they or their spouse were still working and were covered under a group health plan from an employer or union, they may sign up for Part B at any time while covered under the group health plan based on that employment. They may also pick up Part B during the eight-month period that begins the month the employment ends or the group health plan coverage ends, whichever comes first. Usually, if they join Part B during this special open enrollment period, a penalty will not apply.

Part B premiums are based on income and may increase every year.

Medicare Part C

Part C refers to a Medicare Advantage health plan offered by a private insurance company.

In an **HMO-POS** (Health Maintenance Organization–Point of Service), the primary care physician coordinates the member's health care. The benefits available under an HMO-POS are usually better than those available under Original Medicare. Members are able to choose doctors who may or may not be in the plan's network. Members will pay more for care received from non-network providers. If they receive care from an in-network provider, they pay their in-network co-pay. If the care they receive is given by providers outside of the plan's network, the plan will cover a portion of the costs. An MVP Medicare Advantage plan covers 70% of the member's out-of-network costs, up to $5,000 annually.

In a **PPO** (Preferred Provider Organization), members are not required to have a primary care physician or seek a referral to see another doctor. Some services may require a prior authorization. MVP® USA Care PPO® works similarly to our HMO-POS plans. However, with MVP USA Care PPO, the out-of-network coverage is unlimited. A PPO gives the member the choice of receiving services within the participating provider network or outside of the provider network. Residency requirements vary based on product.

An **MSA** (Medical Savings Account) combines a $0 premium, high-deductible medical Medicare Advantage plan with a Medicare contribution into a tax-exempt trust or custodial savings account, giving the member freedom to choose how they spend their health care dollars. MSA members may see any eligible provider in the U.S. who is willing to supply services to Medicare patients. Some services may require prior authorization by MVP. Medicare MSAs do not include Part D prescription drug coverage. To avoid a Medicare penalty, MSA members

should enroll separately in a Medicare Prescription Drug Plan (PDP) or have drug coverage that is as good as Medicare's standard.

A **PDP** (Prescription Drug Plan) provides Medicare Part D prescription drug coverage only. The standalone drug plan option can be paired with a non-Medicare Advantage medical plan.

Medicare Part D

Part D is the Medicare prescription drug benefit offered by private insurance companies.

Part D provides access to prescription drug insurance coverage for individuals who are enrolled in Medicare Part A and/or enrolled in Part B.

Part D benefits are not directly available through Medicare like Parts A and B. The benefits are purchased through a health plan or standalone prescription drug provider.

If a person does not sign up for Part D when first eligible and enrolls at a later date, they may pay a late enrollment penalty for each month not enrolled, plus the current Part D premium for as long as they have a Part D plan.

Not all employer group commercial prescription drug riders are creditable coverage. To be creditable, the prescription benefit must provide a benefit that is at least as good as Medicare Part D. Any benefit with a calendar year maximum is not creditable. High-deductible health plans—where the prescription drugs are subject to the deductible—are not always creditable. When a person's coverage is not creditable and they join a Part D plan after they turn 65, they may be subject to a late enrollment penalty.

If a person was eligible, but did not enroll in a Part D plan previously because they had creditable prescription drug coverage, they must produce a creditable coverage certificate(s) when they do want to enroll. The certificate(s) is provided by the employer annually. The certificate(s) must show continuous creditable coverage back to the start of Medicare Part D, January 1, 2006, or when the person was first eligible for Part D.

MVP offers Medicare Advantage plans with Part D prescription drug coverage. When a person enrolls in an MVP Medicare Advantage plan with prescription drug coverage, the person is enrolled in Medicare Part D.

A word about higher Part D premiums for seniors with higher incomes and income related monthly adjustment amounts (IRMAA). The Patient Protection and Affordable Care Act provides for a reduction in the Medicare Part D premium subsidy for Medicare beneficiaries who earn a higher income. The new provision parallels the Medicare Part B premium adjustments and the result is that people with an annual income over $87,000 single (or over $174,000 for couples filing jointly) will pay a higher monthly Part D premium. The increased premium will be a percentage based on the national base Part D premium. The amount of the additional premium will be deducted directly from the beneficiary's Social Security check, regardless of the premium payment method chosen by the beneficiary.

For additional information about Creditable Coverage, visit **cms.org** and select *Medicare*, then *Creditable Coverage* under the **Prescription Drug Coverage** heading.

Medicare Advantage HMO-POS, PPO, MSA, and PDP

The Centers for Medicare & Medicaid Services (CMS) pays MVP a monthly premium for each Medicare-eligible person enrolled in a Medicare Advantage plan. CMS reimbursement varies by county, which determines regional premiums.

Eligibility Requirements

A person is eligible to enroll in an MVP Medicare Advantage plan if they:

- Are enrolled in Medicare Parts A and B by virtue of being age 65, or have Medicare Parts A and B due to a disability.
- **Are not actively working for an employer of 20 or more employees.** However, if they get Medicare Part A and Part B, and decline the employer's commercial plan, then they are eligible to enroll in a direct bill Medicare Advantage plan.
- Reside for six months or more per calendar year in the MVP service area, except for those enrolled in USA Care PPO.
- Do not have End Stage Renal Disease (ESRD) prior to enrolling, unless:
  - They developed ESRD while enrolled as an MVP Health Care commercial health plan member.

- They are diagnosed after the date of signature on the enrollment form
- An employer group converts to MVP Health Care exclusively

Frequently Asked Questions: **Eligibility**

Q: If a person turns age 65 on August 22 and another person turns 65 on September 1, what is the effective date of Medicare for each of them?

A: The first person is eligible on the first of the month in which they turn 65, or August 1. The second person would also become eligible for Medicare on August 1. Individuals born on the first of a month become eligible for Medicare on the first of the previous month.

Q: Is a person always eligible for Medicare when they turn age 65?

A: Not always. If someone has not paid enough Medicare taxes (40 quarters or 10 years in Medicare-covered employment), they will not be eligible for Medicare. They may be eligible for Medicare through their spouse.

Q: What if the employee is age 65 and not eligible for Medicare, but their spouse is age 60 and still working?

A: In this case, the employee is not eligible until the spouse goes on Social Security or becomes eligible for Medicare. Call your broker or MVP account representative for more information.

New-To-Medicare Process

Most often, Commercial MVP members are notified by MVP at several checkpoints between ages 64 and 65 to market MVP Medicare Advantage plans to them (this does not apply in cases where an employer group is excluded from the age-in process). If retiring, they are sent a packet that explains the plan coverage appropriate to them, based on the Medicare Advantage plan offered through the employer. If the employer does not offer an MVP Medicare Advantage plan, the member may be eligible to enroll in an MVP Medicare Advantage individual bill plan.

Members receive an *Actively Employed Information* form and are instructed to complete it with their employer. The employer should complete the *Actively Employed Information* form if the employee will continue working past age 65 or if the employee will continue to work and cover his/her spouse who is turning 65.

By completing the *Actively Employed Information* form, you (the employer) are validating that:

1. Your company employs 20 or more employees;
2. The employee who carries the MVP policy is not retiring, but will continue to work for you as an active employee past age 65, or will continue to work when his/her spouse turns 65; and
3. You will continue to provide the same health benefits under the same conditions to Medicare-eligible employees and the Medicare-eligible spouses of employees, as you provide to employees and spouses who are not Medicare-eligible. You are required to notify MVP upon retirement of the employee.

A sample *Actively Employed Information* form can be found on page 20.

Frequently Asked Questions: **New-to-Medicare Process**

Q: How and when are MVP commercial plan members who are about to become Medicare-eligible notified by MVP that they are eligible to enroll in an MVP Medicare Advantage plan?

A: Each month, reports are generated listing all the MVP (non-Medicare) members who will be turning 65 in 90 days. Enrollment information is provided to the members on this list. Some members are excluded from this process.

Q: What if a member continues to work past age 65, or the member retired, but their spouse continues to work?

A: If an MVP member continues to work after age 65, the member will need to complete an *Actively Employed Information* form (included in the age-in packet) for notification that they or their spouse will be working. The member also needs to notify Social Security that they will still be employed after age 65.

Special rules apply. See **Medicare Secondary Payer** on page 8 for more information.

Completing the Enrollment Form

The first step in the enrollment process is to have your retiree and their spouse each complete an employer group enrollment form. You need to review the information to make sure all sections are complete. After your review, the forms may be sent to MVP by:

- email to **goldenrollment@mvphealthcare.com**
- fax to **585-327-2227**
- mail to MVP Health Care Medicare Enrollment, 220 Alexander St., Rochester, NY 14607

When a form is received:

- It will be date stamped on the date it is received
- It will be reviewed to make sure all the information is complete
- Verification of the enrollee's Medicare eligibility will be done
- When the enrollment form meets all the eligibility criteria, it will be processed within five business days or less

Completing The Employer Group Enrollment Form

Step 1
Plan Enrollment Selection for Employer Group or Union Members

1. Enter the employer or union name and group number
2. Check the appropriate MVP Medicare Advantage health plan

Step 2
Member Information

1. Enter the retiree's last name, first name, and middle initial
2. Enter the retiree's permanent street address, and mailing address, if different
3. Enter the retiree's date of birth and gender
4. Retiree's email address is optional.

Step 3
Medicare Card Information

1. Review the retiree's red, white, and blue Medicare card
2. Enter the retiree's name exactly as it appears on the Medicare card
3. Enter the Medicare Beneficiary Identifier
4. Enter the dates for hospital (Part A) and medical (Part B), the retiree must have effective dates for Parts A and B

Note: MVP does not need a copy of the Medicare card.

Step 4
Primary Care Physician (PCP)

Each retiree and spouse enrolled in the MVP Preferred Gold HMO-POS plan must choose a primary care physician (PCP) within the MVP provider network. Retirees enrolled in the USA Care PPO plan are not required to select a PCP. Providers are listed in the MVP provider directory of health care professionals. The most up-to-date listing is available at **mvphealthcare.com/findadoctor**.

1. Enter the PCP's full name. The Primary Care Physician selection is not required for a PPO plan
2. Check the appropriate box to indicate whether the employee is or is not an existing patient

Step 5
Please Read and Answer These Important Questions

Each of the questions in this section must be answered.

Step 6
Signature and Authorization

1. The retiree provides his or her signature and date after the disclosure and release of information
2. An authorized representative with Power of Attorney or a Court Appointed Guardian may sign the enrollment form. A copy of the Power of Attorney or Court Appointed Guardian form must be provided if requested by MVP or by Medicare
3. A copy of creditable coverage notices will be required when a Medicare-eligible member has been enrolled in coverage other than Part D coverage. If creditable coverage has not been determined upon enrollment, a *Creditable Coverage Attestation* packet will be mailed to the enrollee. If the questionnaire is not completed and returned within 30 days from the date of the letter, a late enrollment penalty could be charged.
4. Member information will be audited after it is processed. This confirms the information to create the enrollee's ID card.
5. If the retiree is being moved from other coverage that was creditable, the employer may provide attestation of the creditable coverage using the *MVP Attestation of Creditable Coverage* (see sample on page 14).

The Enrollment Process

The employer designates a time period as its group **open enrollment period**.

Your retiree should complete an MVP Medicare Advantage plan Employer Group enrollment form and return it to you 60 days before the retiree's Medicare effective date. This will allow you enough time to review and return the form to MVP for processing.

MVP will process the enrollment and send the enrollment information electronically to CMS. The enrollment should be sent to us at least 30 days before the requested effective date, but exceptions can be made to the 30 days. If enrollment forms are received and processed outside the 30-day time frame, there may be a delay in sending member ID cards and benefit information.

When the enrollment is processed, a letter will be sent to the potential member informing them that their application was received and sent to CMS for approval.

The MVP Enrollment Department can accept a complete enrollment form up until the last work day of the month and still have the enrollee effective on the first day of the next month.

The member's signature on the enrollment form must be dated prior to the effective date.

Once CMS notifies MVP of the approval of the enrollment, the member is officially enrolled. The member will receive ID cards and an Evidence of Coverage (contract).

Per CMS regulations, MVP only covers single contracts. Spouses must complete their own enrollment form.

Frequently Asked Questions: Enrollment Processing Questions

Q: How far in advance of the effective date can a person sign and date an enrollment form?

A: A person whose health care coverage is sponsored by an employer group may sign an enrollment form up to 90 days prior to the effective date.

Q: How far back may a person retroactively enroll?

A: A person whose health coverage is sponsored by an employer group plan may be retroactively enrolled in a Medicare Advantage product up to 90 days, provided the enrollment form was signed and dated prior to the retroactive effective date. Also, employer authorization must be date stamped prior to the effective date. If the requested enrollment effective date is January 1, the signature and employer authorization stamp need to be dated before January 1. Retroactive enrollment can take CMS up to 90 days to approve or deny.

Q: Is the first of the month always the effective date for enrollment and disenrollment?

A: Yes.

Q: Per CMS guidelines, what constitutes proof of a person's legal, permanent address?

A: To enroll in an MVP Medicare Advantage plan (except for MVP USA Care PPO) a person must permanently reside in the plan service area. Per CMS, permanent residence may be validated using any of the following:

- Voter registration
- Property tax records
- Utility bill
- Driver's license

A post office box is not acceptable as proof of permanent residence.

Q: Can a person who lives in a county outside the plan service area enroll in an MVP Medicare Advantage health plan?

A: A person must reside in the plan service area (except for MVP USA Care PPO).

Q: How long may an MVP Medicare Advantage plan member live outside the plan service area?

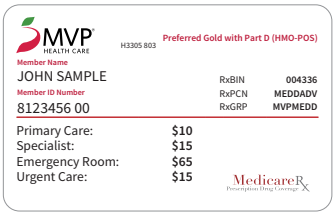
A: Per CMS regulations, these members may temporarily reside out of the plan service area for up to six consecutive months (except for MVP USA Care PPO members).

If a member permanently moves out of the plan service area, they will be disenrolled. The effective date of the termination will be the first day of the month following the date of the move. Written verification of the move by the member or the employer group will be accepted.

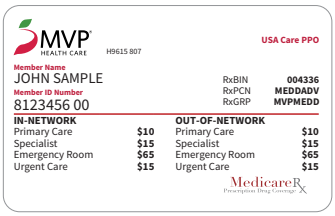
In some cases, CMS may become aware of the member's permanent move out of the plan service area and will automatically terminate the member.

Member Identification Cards

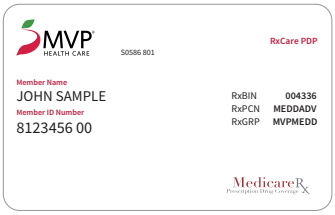
MVP Preferred Gold HMO-POS



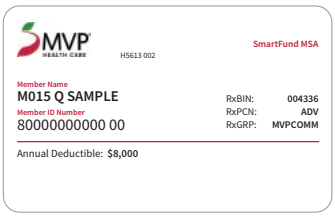
MVP USA Care PPO



MVP RxCare PDP



MVP® SmartFund® MSA



New members can expect to receive their identification cards within two weeks after their enrollment is approved by CMS.

Member ID cards do not have an end date. Members whose coverage and co-pays do not change from year to year will be able to continue using the same ID card. Member ID cards are not automatically reissued on a yearly basis if the information on the card (e.g., co-pays, Primary Care Physician, subscriber name) remains the same.

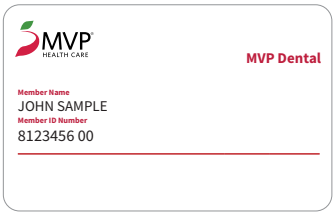
If the member requests a replacement card, allow up to two weeks to receive a new card. If a member needs a card to receive services, they can print one through the *Members* section at **mvphealthcare.com/members**.

Members must present their MVP plan ID card, not their Medicare card, for medical services. Members should keep their red, white, and blue Medicare card in a safe place.

Dental Identification Care

MVP Dental Plan

Group plans that include a Dental Rider



New members can expect to receive their dental ID card within two weeks after their enrollment has been approved by CMS.

Dental ID cards do not have an end date. Dental ID cards are not automatically reissued on a yearly basis if the information on the card remains the same.

If the member requests a replacement card, allow up to two weeks to receive a new card. If a member needs a card to receive services, they can print one through the *Members* section at **mvphealthcare.com/members**.

Members must present their MVP dental plan ID card, not their Medicare card, for dental services.

Members have access to the DenteMax dental network of more than 260,800 dentists and dental practices throughout the United States. Generally, members' costs will be lower if they are treated by a dentist in the DenteMax network—dentists have agreed to charge a standard, fixed amount as payment in full for a wide range of dental services.

If members choose to go to a dentist who is not part of the DenteMax network, they may pay more if the dentist's charge for services is more than the fixed DenteMax amount.

Medicare Plan Dental Benefit

Fee Schedule and Balance Billing

All Medicare plan-covered dental benefits pay up to the DenteMax network maximum fee. Members who use a

DenteMax dentist will not be balance billed and generally have lower out-of-pocket costs.

Members who choose to go to a dentist who is not part of the DenteMax network may be balance billed if the dentist's charge for services is more than the DenteMax maximum fee. The balance billed amount may be more than the member paid for services. Members may also use DenteMax network dentists to save on services not covered by MVP.

Members are responsible for all costs above annual allowance ($240 per year for HMO-POS; $300 per year for PPO).

Annual Dental Allowance

Preferred Gold with Part D–Rider
$240 per year for preventive services: exams, adult prophylaxis (cleaning), periodontal maintenance, or x-rays.

USA Care with Part D–Rider
$300 per year for any dental service (not limited to preventive services).

Disenrollment/Termination

Voluntary Disenrollment (Member Initiated)

MVP may accept disenrollment requests directly from the Employer Group or Union without obtaining a written disenrollment request from the member. Disenrollments may only be prospective from the date the request is received by the employer group or union.

Involuntary Disenrollment (Employer Group Initiated)

The employer must notify the member of the disenrollment intent 30 days prior to the disenrollment effective date. Prospective notice must include information about other plan options and how to request enrollment in those options, such as an MVP direct bill plan. A copy of this notification must be provided to the MVP Medicare Enrollment Department 30 days prior to contract termination when an employer group or union:

- terminates its contract with MVP, or
- determines that a member is no longer eligible to participate in the group/union sponsored plan, the employer/union will provide MVP with a 30-day notice of contract termination or the ineligibility of a member to participate in the sponsored plan.

This notice must be prospective, not retrospective.

If the employer/union-sponsored plan was a Medicare Advantage plan with Part D, the member must be advised that the disenrollment action means they will no longer have Medicare Part D drug coverage and the potential of a late enrollment penalty if they do not enroll in other coverage within 63 days.

Disenrollment notification can be sent to MVP by:

- email to **goldenrollment@mvphealthcare.com**
- fax to **585-327-2227**
- mail to MVP Health Care, Medicare Enrollment, 220 Alexander St., Rochester, NY 14607

Retroactive Disenrollment

Disenrollments may be made retroactive under extremely limited circumstances. They must be justified in writing by the employer or member (or a representative). Supporting documentation must be produced to prove that information was received timely by the employer and the employer failed to inform MVP of the termination prior to the effective date. It may take 90 days or more to receive approval from CMS for retroactive disenrollments.

Please note: If you are terminating a member or members from your MVP Medicare Advantage health plan, contact your account representative and notify MVP's Medicare Enrollment Department. Prospective terminations can be processed from a written request by email. You can also fax the request in writing (no official form required) to MVP Medicare Enrollment at **585-327-2227**.

Frequently Asked Questions: COBRA

Q: What happens if a person has COBRA and enrolls in Medicare?

A: If a member already has continuation coverage under COBRA when they enroll in Medicare, the COBRA coverage may end. The employer has the option to cancel the continuation coverage at this time. The length of time a spouse may receive coverage under COBRA may change when the member enrolls in Medicare.

Q: What happens if a person has Medicare and chooses to get COBRA?

A: If a person is already enrolled in Medicare, they can elect COBRA coverage during the COBRA election period. If they only have Medicare Part A when their group health plan coverage ends (based on current employment), they can enroll in Medicare Part B during a Special Enrollment Period without having to pay a higher Medicare Part B premium. They have to sign up for Medicare Part B within eight months after the group health plan coverage ends (the coverage that allowed you to go on COBRA, not the COBRA coverage) or when the employment ends, whichever is first. If they don't sign up for Medicare Part B during the eight-month Special Enrollment Period, or when their employment ends or they lose coverage, they will only be able to sign up during the General Enrollment Period and the cost of Medicare Part B may go up. The General Enrollment Period is January 1–March 31 with an effective date of July 1.

If a person is covered under COBRA, their employer group health plan may require them to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is before the employment ends or the person loses coverage. If they wait to sign up for Part B during the last part of their Special Election Period (the eight months after their employment or coverage ends), the employer could make the member pay for services that Medicare would have paid for if the member had signed up earlier. State law may give the member the right to continue coverage beyond the point COBRA coverage ends.

More information is available in *An Employer's Guide to Group Health Continuation Coverage Under COBRA*.

Medicare Carve-Out

If you decide that you are going to allow Medicare-eligible retirees to remain in your MVP commercial plan after they become Medicare-eligible, you must contact your MVP account manager to facilitate this process. There are some important things you need to know if this is to be allowed:

- Medicare is still primary.
- MVP will coordinate our benefits with Medicare.
- MVP is responsible for coverage only to the extent that Medicare would not have covered a service or item, whether or not the member elects to take Part B. If the member does not elect to take Part B, the portion of the claim that would have been covered by Part B must be paid by the member; it will not be paid by MVP.
- Your contribution to premium payments must be the same amount or percentage as for your retirees who elect an MVP Medicare Advantage plan.
- The option must be offered to all retirees. Once the retiree leaves the commercial plan, they will not be allowed back into the plan.

Medicare Secondary Payer

To preserve Medicare for future generations, Congress passed a series of laws delineating who is primary and who is secondary when Medicare is involved, as well as expanding the time when a commercial health plan is primary to Medicare.

- These laws affect active employees and dependents of active employees.
- Medicare is always primary once the employee retires.
- Medicare's rules for determining, documenting, and processing claims for Medicare Secondary Prayer can be accessed by visiting **cms.gov** and selecting *Regulations & Guidance*, then *Manuals* under Guidance, then *Internet-Only Manuals (IOMs)*, and then *100-05 Medicare Secondary Payer Manual*.

Medicare Secondary Payer applies to employees and spouses age 65 or older, who are entitled to Medicare and who are still actively employed and eligible for health coverage through the employer's health plan.

Working Aged

Medicare Secondary Payer rules require an employer with 20 or more employees to make group health coverage available to active employees age 65 or older and to active employees' spouses who are eligible for Medicare. Medicare-eligible individuals, who have elected the group health plan as the primary insurer, may delay purchasing Medicare Part B until they are no longer actively employed.

When Medicare is no longer secondary through a change in employment status or a change in the employer size, the member is eligible for a Special Enrollment Period to obtain Part B without a penalty.

If an individual qualifies for Medicare due to partial or total disability, the employer group health plan is always primary until the member qualifies for Medicare.

- Medicare-eligible disabled individuals who are no longer working due to their disability, regardless of employer size, will have Medicare as their primary insurer.
- Medicare is the secondary payer for disabled individuals who continue to work, as well as for disabled spouses of active employees, **for an employer group with more than 100 employees**.
- Medicare is the primary payer for disabled individuals who continue to work, as well as for disabled spouses of active employees, **for an employer group with less than 100 employees**.

Frequently Asked Questions: Medicare Secondary Payer

Q: If an employee who is Medicare eligible decides not to take group health plan coverage from the employer, what other type of health insurance can the employer offer?

A: The employer can offer a plan to the retiree that will pay for services Medicare doesn't cover, such as hearing aids or routine dental checkups. The employer can't offer a plan that pays supplemental benefits for Medicare-covered services or pays for these benefits in another way. For example: the employer cannot provide a Medicare Advantage plan or supplemental plan.

Q. How do you count the "20 employees" rule?

A. The rule applies if an employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees subsequently drops below 20.

Q. Do Medicare Secondary Payer laws apply to Part D (Prescription Drugs)?

A. Yes, the same laws and processing rules apply as does a late enrollment penalty for not enrolling when a person is first eligible for Part D.

Who is Primary?

Medicare is primary in these specific situations:

- **Under 20 full-time employees** and member is an **active** employee or dependent
- **Under 20 full-time employees** and member is a **retired** employee or dependent
- **Over 20 full-time employees** and member is a **retired** employee or dependent
- **Under 100 full-time employees** and member is a disabled **active** employee or dependent of an active employee
- **Under 100 full-time employees** and member is a disabled **retired** employee or dependent of an retired employee
- **Over 100 full-time employees** and member is a disabled **retired** employee or dependent of a retired employee

Commercial plan is primary in these specific situations:

- **Over 20 full-time employees** and member is an **active** employee or dependent
- **Over 100 full-time employees** and member is a disabled **active** employee or dependent of an active employee

More information is available in the CMS publication, *Your Guide to Who Pays First*, available at **medicare.gov/pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf**.

Premium Invoice

Information About Your Invoice

Your premium invoice is based on your group's enrollment information at the time the invoice is produced. The invoice will reflect all additions, terminations, and changes received at least four business days before the invoice is produced.

Changes may occur in your invoice statement based on information received from CMS, such as Low Income Subsidy and Late Enrollment Penalty notifications. Changes to your retiree's status concerning their eligibility for low income subsidies for Medicare Part D will change their monthly premium rate. See *Low Income*

Subsidy Eligibles on page 11 that describes the subsidy classifications.

Reconciling and Paying Your Invoice

Reconciling your invoice each month will help you confirm the accuracy of your payment. Check your invoice before sending in your payment to make sure you are being billed for the correct members. Your invoice will give you all the information you need to compare your records to ours.

Changes or adjustments to your group's membership must be emailed directly to **goldenrollment@mvphealthcare.com**, or faxed to **585-327-2227**. Please note that MVP has retroactivity guidelines that must be followed. To avoid possible denial of your changes, please ensure that all membership changes are submitted timely.

Full payment of the invoice amount is necessary in order to avoid delinquency letters and possible termination. Your invoice total can be found on page 1 of your bill. Full payment must be made within 30 days of the due date.

Pay On Time and Avoid Medicare Regulatory Issues

Regular monthly payment of your MVP invoice ensures that Federal Medicare regulations concerning delinquent payment do not go into effect and negatively impact your group retirees. The following example illustrates what unfolds, by law, if your premium payment becomes delinquent:

May 15: MVP mails your June invoice.

By June 1: MVP must receive your June payment by this date.

July 5: If MVP has not received payment by July 3, a late letter mails to your group explaining that per Medicare regulations, your group will be terminated if full payment for June and July is not received by July 31.

By July 10: Per Medicare regulations, MVP mails 21-day notification letters to your group retirees stating possible termination of health plan coverage for non-payment by their employer.

Mail payments to the address noted on the invoice and include both your group and subgroup number on the check. This will ensure timely and accurate posting of your payment. Please do not submit membership changes with your payment.

Go Paperless with MVP eBilling!

MVP offers the convenience of eBilling as a paperless option to view your invoice or pay your monthly invoice. Sign in to your online MVP account at **mvphealthcare.com** to:

- **View your invoices**—a summary of the last invoice is displayed as well as the current balance
- **Print invoices** in Adobe PDF format
- Choose to make one-time payments or set up recurring payments online
- Edit, change, or cancel direct debit without filling out a form

To learn more, contact your MVP Account Representative.

Dual Eligibles–Full/Partial and Low Income Subsidy Benefit Descriptions

Full Benefit Dual Eligibles

CMS notifies MVP of the dual eligibility status of your retirees and requires the plan to enroll the retiree in their current MVP Medicare Advantage plan. This could be retroactive based on the full dual eligibility effective date.

Dual eligible individuals have Medicaid coverage with prescription drug benefits that are covered under Part D. Individuals residing in nursing homes have no co-pay for Part D drugs. Individuals not residing in an institution, but who are Full Benefit Dual Eligible, may have a small co-pay for Part D drugs.

Premium

You will see a different premium amount on your monthly billing statement for those retirees in a Full Dual Benefit category based on the low income subsidy amount for Part D that CMS pays. Due to the fact that CMS notification may take a month or two, you will most likely see a retroactive adjustment. Retirees with dual eligible subsidies will appear on the employer group bill with a reduced premium.

Employer groups must credit the person's bill with the Low Income Subsidy Eligible (LIS) subsidy amount. Please note that these amounts are generally one month behind.

If the retiree pays any portion of their premium, this LIS amount must be used to reduce the retiree's premium.

Low Income Subsidy Eligibles

Retirees may qualify for a subsidy for Medicare Part D based on their income/assets. The subsidy provides assistance with the premium, deductible, and co-payments of the Part D program. Retirees may apply for the Low Income Subsidy (LIS) with the Social Security Administration or with the New York State Medicaid agency.

CMS will notify MVP if any of your retirees are eligible for LIS. Upon notification, MVP is mandated by CMS to enroll these retirees into the appropriate LIS level.

Employer groups must credit the person's bill with the LIS subsidy amount.

Late Enrollment Penalty

Medicare beneficiaries who do not join a Medicare drug plan when they are first eligible for Medicare Part A and/or Part B, and who go without creditable prescription drug coverage for 63 days or more, may have to pay a late enrollment penalty to join a Part D plan later. Late Enrollment Penalty (LEP) amounts will always be a month behind. Employers may include this amount in the member's monthly premium payment. This penalty amount changes every year. The beneficiary will have to pay it each month as long as he or she has Medicare prescription drug coverage.

If You Have Questions

Call your broker or MVP account representative for help with questions on completing the enrollment form or benefit questions. Call your accounts receivable representative for billing questions. This is on the top left of the invoice.

If your retirees have questions about their health care coverage, they may contact the MVP Medicare Customer Care Center at the phone number listed below. This number also appear on the back of their MVP Member ID cards.

MVP Representatives are available to help with:

- Changing doctors
- Benefit details
- Appeals/grievances/complaints
- Claims
- An updated list of providers
- Updating or replacing a Member ID card
- Change of address
- And more!

Contacts for Retirees

MVP Medicare Customer Care Center

1-800-665-7824 (TTY: 1-800-662-1220)
Seven days a week, 8am–8 pm Easter Time
April 1–September 30, Monday–Friday, 8 am–8 pm
Or visit **mvphealthcare.com**.

Medicare

1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048
24 hours a day, seven days a week
Or visit **medicare.gov**.

MVP Medicare Member Documents Available Online

To access any of the following PDF documents online, visit **mvphealthcare.com/medicare** and select *Forms/Resources*.

- **MVP Medicare WellBeing Rewards Benefit Information**
- **Medical and Dental Claim Reimbursement Request**
- **Eye Glasses/Contact Lens Reimbursement**
- **CVS Caremark Medicare Part D Prescription Claim (includes Vaccine Reimbursement)**
- **CVS Caremark Mail Service Order**

MVP HEALTH CARE

Forms and Letters
Reference

Forms and Letters Reference

Change of Address or Plan Cancellation

Change of Address or Plan Cancellation
for Medicare Employer Group Plan Members

Action Requested *(check one)*:

- ☐ **Permanent Change of Address** — Complete Sections 1 and 2
- ☐ **Temporary Change of Address** — Complete Sections 1 and 3
- ☐ **Cancellation** — Complete Sections 1 and 4

Section 1: Member Information *(please print)*

Employee Name *(Last, First Middle Initial)* | Date of Birth

MVP Member ID Number | Medicare Number | Group Number | Group Name

Section 2: Permanent Change of Address Information

Effective Date of Change | Street Address (**PO Box is not allowed**)

City | State | Zip Code

Mailing Address, if different from Permanent Address

City | State | Zip Code

Section 3: Temporary Mailing Address Information

Effective Dates of Change *(if applicable)* **From** **To** | Street Address

City | State | Zip Code

Section 4: Cancellation

Effective Date of Cancellation

Employer Group Representative Signature *Date*

*Please return this completed form to your MVP Medicare Account Manager or MVP Medicare Enrollment at **goldenrollment@mvphealthcare.com**.*

Questions?

Call the MVP Medicare Customer Care Center at **1-800-665-7924** (TTY: **1-800-662-1220**)
Monday–Friday, 8 am–8 pm Eastern Time. October 1–March 31, call seven days a week, 8 am–8 pm.

Y0051_3323 MVPform0093 (05/2019)

Forms and Letters Reference

Attestation of Creditable Coverage
Prescription Drug Coverage for Part D Employer/Union Retiree Group Plans

220 Alexander Street
Rochester, NY 14607-4002
mvphealthcare.com

Attestation of Creditable Coverage Prescription Drug Coverage for Part D Employer/Union Retiree Group Plans

"Creditable prescription drug coverage" generally means prescription drug coverage that is expected to pay at least as much as Medicare's standard prescription drug coverage. Creditable prescription drug coverage includes, but is not limited to: some employer-based prescription drug coverage, including the Federal Employees Health Benefits program; qualified State Pharmaceutical Assistance Programs; military-related coverage (e.g., VA, TRICARE); and certain Medicare supplemental (Medigap) policies. For detailed information on Creditable Coverage, please visit: http://www.cms.gov/CreditableCoverage/.

Employers and unions who enroll groups of beneficiaries into Medicare prescription drug coverage may attest to their members' creditable coverage history by completing the following question:

Are your prescription drug plans Creditable?

☐ **All** of our employees are covered by a prescription drug plan that is Creditable.

☐ **Some or None** of our employees are covered by a prescription drug plan that is creditable. Time period Creditable Coverage was not in force:
From date: _____ to date: _____

NOTE:
If the first box is checked, MVP will not send out any Creditable Coverage questionnaires to your retirees or eligible spouses on your group health plan. If the second box is checked, MVP will send out Creditable Coverage questionnaires to your retirees or eligible spouses on your group health plan.

Please send the completed form to:
MVP Health Care – Medicare Enrollment
220 Alexander St., Rochester, NY 14607
Fax: 1-585-327-2227
Email: goldenrollment@mvphealthcare.com

_____ _____
Group Name: Group Number:

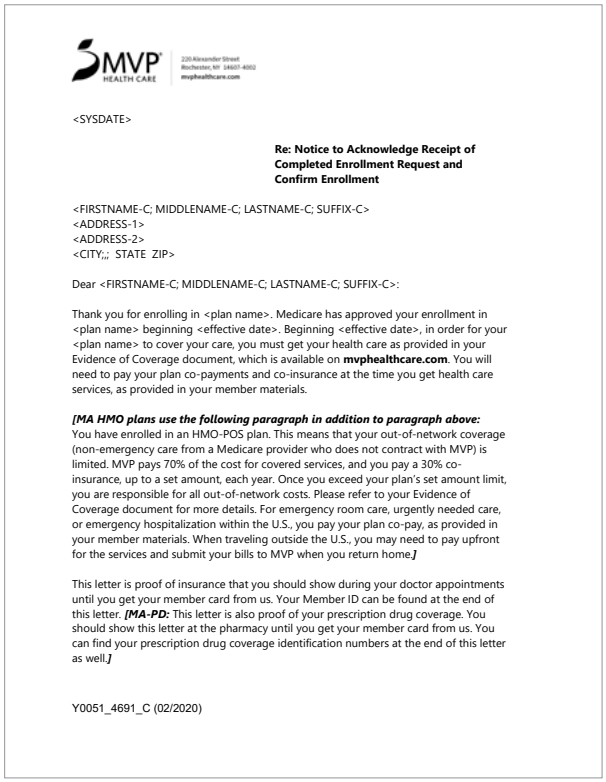
_____ _____
Authorized Representative Signature Date

_____
Authorized Representative Name and Title (*Please Print*)

Y0051_1291 (01/12)

Forms and Letters Reference

Notice to Acknowledge Receipt of Completed Enrollment Request and Confirm Enrollment Letter



MVP HEALTH CARE
220 Alexander Street
Rochester, NY 14607-4002
mvphealthcare.com

<SYSDATE>

Re: Notice to Acknowledge Receipt of Completed Enrollment Request and Confirm Enrollment

<FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C>
<ADDRESS-1>
<ADDRESS-2>
<CITY;;; STATE ZIP>

Dear <FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C>:

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Beginning <effective date>, in order for your <plan name> to cover your care, you must get your health care as provided in your Evidence of Coverage document, which is available on **mvphealthcare.com**. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.

[MA HMO plans use the following paragraph in addition to paragraph above:
You have enrolled in an HMO-POS plan. This means that your out-of-network coverage (non-emergency care from a Medicare provider who does not contract with MVP) is limited. MVP pays 70% of the cost for covered services, and you pay a 30% co-insurance, up to a set amount, each year. Once you exceed your plan's set amount limit, you are responsible for all out-of-network costs. Please refer to your Evidence of Coverage document for more details. For emergency room care, urgently needed care, or emergency hospitalization within the U.S., you pay your plan co-pay, as provided in your member materials. When traveling outside the U.S., you may need to pay upfront for the services and submit your bills to MVP when you return home.***]***

This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. Your Member ID can be found at the end of this letter. ***[MA-PD:*** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us. You can find your prescription drug coverage identification numbers at the end of this letter as well.***]***

Y0051_4691_C (02/2020)

[MA-PD plans insert the following two paragraphs if no low-income subsidy:
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

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 think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.***]***

[MA-PD plans add the following paragraph if low-income subsidy applicable:
What are my costs since I qualify for Extra Help?
Because you qualify for Extra Help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> co-payment when you fill a prescription covered by <plan name>.

If you believe this is incorrect and you have proof that the Extra Help amounts should be different, please contact <plan name>.***]***

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

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

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

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

[Zero premium plans do not include the following:
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must continue with the option you choose for the rest of the year. Members who fail to pay the monthly plan premium may be disenrolled from <plan name>. If you have any questions, please call the MVP Medicare Customer Care Center at **1-800-665-7924,** Monday – Friday from 8 am to 8 pm Eastern Time. From October 1 – March 31, call seven days a week from 8 am to 8 pm. TTY users may call 1-800-662-1220.

[MA-PD plans with a premium include the following: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.***]*** ***[Zero premium plans do not include the following:*** We will bill you for the portion of your monthly premium that you owe.***]***

When can I make changes to my coverage?

You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch, or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). 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.

If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first three months you have Medicare.

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to leave (disenroll from) <plan name> and buy a Medigap policy. Please contact **1-800-MEDICARE (1-800-633-4227)** anytime, 24 hours a day/7 days a week, for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call the MVP Medicare Customer Care Center at **1-800-665-7924,** Monday – Friday from 8 am to 8 pm Eastern Time. From October 1 – March 31, call seven days a week from 8 am to 8 pm. TTY users may call 1-800-662-1220. Please be sure to keep a copy of this letter for your records.

Thank you.

<signature/title>

<Member # >
<RxGroup>
<RxBin>
<RxPCN>

Forms and Letters Reference

Notice to Acknowledge Receipt of Completed Enrollment Request and Confirm Plan Change Letter

<logo>

<*SYSDATE*>

Re: Notice to Acknowledge Receipt of Completed Enrollment Request and Confirm Enrollment Plan Change

<*FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C*>
<*ADDRESS-1*>
<*ADDRESS-2*>
<*CITY;,; STATE ZIP*>

Dear <*FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C*>:

Thank you for your request to change your enrollment with MVP Health Care. Medicare has approved your enrollment in <plan name> beginning <effective date>.

How will this plan work?
Beginning <effective date>, you must see your <new plan name> doctor(s) for your health care. This means that starting <effective date>, all of your health care, except emergency or urgently needed care, or out-of-area dialysis services, must be given or arranged by a <new plan name> doctor(s). You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials. Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.

[MA PPO plans use the following paragraph in place of paragraphs above: Thank you for your request to change your enrollment with MVP Health Care. Medicare has approved your enrollment in <new plan name> beginning <effective date>. Beginning <effective date>, you must get your health care as provided in your "Evidence of Coverage". You will need to pay your plan co-payments and co-insurance at the time you get health care services, as provided in your member materials.***]***

This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us. ***[MA-PD:*** This letter is also proof of your prescription drug coverage. You should show this letter at the pharmacy until you get your member card from us.***]***

[MA-PD plans insert the following two paragraphs if no low-income subsidy:
What are my costs on this plan?
The monthly premium for your plan is <insert premium>.

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 ww.socialsecurity.gov/prescriptionhelp. If you think you qualify for Extra Help with your prescription drug costs, but you don't have or can't find proof, please contact <plan name>.***]***

[MA-PD plans add the following paragraph if low-income subsidy applicable:
What are my costs since I qualify for Extra Help?
Because you qualify for Extra Help with your prescription drug costs, you will pay no more than:

- A monthly premium of <insert premium less amount of premium assistance for which the individual is eligible>,

- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,

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

If you believe this is incorrect and you have proof that the Extra Help amounts should be different, please contact <plan name>.***]***

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

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

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

As you did not previously have a late enrollment penalty with us, you will not have a late enrollment penalty with this enrollment change.***]***

[Zero premium plans do not include the following:
How do I pay my premium?
Your enrollment form included the options for paying your plan premium. If you did not choose one of these options when you enrolled, we will bill you directly. If you chose to have your monthly plan premium automatically deducted from your Social Security or Railroad Retirement Board check, we may have to send you a bill for your first month or two of enrollment if the deduction doesn't start right away. Generally, you must stay with the option you choose for the rest of the year. If you have any questions about how to pay your plan premium, please call the MVP Medicare Customer Care Center at **1-800-665-7924,** Monday – Friday from 8 am to 8 pm Eastern Time. TTY users may call **1-800-662-1220.** From October 1 – March 31, call seven days a week from 8 am to 8 pm. "Members who fail to pay the monthly plan premium may be disenrolled from <plan name>".

[MA-PD plans with a premium include the following: If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium.***]*** ***[Zero premium plans do not include the following:*** We will bill you for the portion of your monthly premium that you owe.***]***

When can I make changes to my coverage?
You can change health plans only at certain times during the year. From October 15 - December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 - March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). 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.

If you join our plan when you first enroll in Medicare, you can switch to another plan or get Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). If you're not happy with your choice in our plan, you can make a change during the first 3 months you have Medicare.

What if I have a Medigap (Medicare Supplement Insurance) policy?
Now that we have confirmed your enrollment, you may cancel any Medigap or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have a trial period during which you have certain rights to leave (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) anytime, 24 hours a day, 7 days a week for further information. TTY users should call 1-877-486-2048.

If you have any questions, please call the MVP Medicare Customer Care Center at **1-800-665-7924,** Monday – Friday from 8 am to 8 pm Eastern Time. TTY users may call **1-800-662-1220.** From October 1 – March 31, call seven days a week from 8 am to 8 pm. Please be sure to keep a copy of this letter for your records.

Thank you.

<signature/title>

<Member # >
<RxGroup>
<RxBin>
<RxPCN>

Forms and Letters Reference

Notice of Employer Group Failure to Pay Plan Premium—Advance Notification of Reduction of Coverage Letter

<logo>

<SYSDATE>

RE: Notice of Employer Group Failure to Pay Plan Premiums - Advance Notification of Reduction in Coverage

<FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C>
<ADDRESS-1>
<ADDRESS-2>
<CITY STATE ZIP>

<Dear FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C;>,

Our records show that we have not received payment for your plan premium as of <premium due date>.

If we do not receive payment in full from your employer by <date grace period expires>, we will enroll you in an Individual bill contract beginning <date>. This change may reduce the amount of health care coverage you have in <plan name>.

If you get medical assistance (Medicaid) from your State (including paying your premiums, deductibles, or coinsurance), you should check with your State Medicaid Agency to find out if they have been paying for, or have stopped paying for, your plan premium. If you are no longer eligible for assistance from Medicaid, you may have a special temporary right to buy a Medigap policy if you voluntarily disenroll from our plan. If you have questions about Medigap policies, you should contact your State Health Insurance Program, "Health Insurance Information Counseling and Assistance Program (HIICAP)" at **1-800-701-0501** to get more information.

If you wish to disenroll from <plan name> and change to Original Medicare now, you should do one of these two things:

1. Send us a signed, written request, including your Member ID number, to: 220 Alexander St., Rochester, NY 14607, Attn: Medicare Enrollment Dept.

2. Call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

You can change health plans only at certain times during the year.

- **From October 15 - December 7**, you can join, switch, or drop a Medicare health or drug plan for the following year.
- In addition, **from January 1 - March 31**, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan).

Y0051_4230_C OVER

Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not have a coverage gap or a late enrollment penalty. Many people qualify for these savings and do not 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 think we have made a mistake, or if you have any questions, please call the MVP Medicare Customer Care Center at **1-800-665-7924,** Monday – Friday from 8 am to 8 pm Eastern Time. TTY users may call **1-800-662-1220.** From October 1 – March 31, call seven days a week from 8 am to 8 pm.

We appreciate the opportunity to help you take on life and live well!

Sincerely,

<signature/title>

<Member # >
<RxGroup>
<RxBin>
<RxPCN>

Forms and Letters Reference

Medicare Involuntary Disenrollment for Failure to Pay the Part D-Income Related Monthly Adjustment Amount Letter

<logo>

<SYSDATE>

Re: Medicare (CMS) Involuntary Disenrollment for Failure to Pay the Part D-Income Related Monthly Adjustment Amount

<FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C>
<ADDRESS-1>
<ADDRESS-2>
<CITY;;; STATE ZIP>

Dear *<FIRSTNAME-C; MIDDLENAME-C; LASTNAME-C; SUFFIX-C>*:

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

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

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

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 Medicare at 1-800-MEDICARE (1-800-633-4227).

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

Please remember, if you don't request reinstatement within 60 days and pay all owed amounts within 3 months, you will not get your coverage back and will have to wait for

Y0051_3844_C (08/2018)

another opportunity to enroll. If you don't have other creditable coverage (prescription drug that is expected to pay on average as much as Medicare), you may have to pay a Part D late enrollment penalty in addition to the monthly Part D-IRMAA and plan premium, if you enroll in Medicare prescription drug coverage in the future.

When can I get Part D coverage?
Medicare limits when you can make changes to your coverage. From October 15 through December 7 each year, you can enroll in a new Medicare Prescription Drug Plan or Medicare health plan for the following year. You may not enroll in a new plan during other times of the year unless you meet certain special exceptions, such as you move out of the plan's service area, want to join a plan in your area with a 5-star rating, or you qualify for (or lose) Extra Help with your prescription drug costs.

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 the MVP Medicare Customer Care Center at **1-800-665-7924,** Monday – Friday from 8 am to 8 pm Eastern Time. TTY users may call **1-800-662-1220.** From October 1 – March 31, call seven days a week from 8 am to 8 pm.

Thank you.

<signature/title>

<Member # >

Y0051_3844_C (08/2018)

Forms and Letters Reference

Employer Group Medicare Advantage Health Plans Enrollment with Part D Application

Medicare Advantage Health Plans
Employer Group Enrollment with Part D Application

By completing this Enrollment Application, I agree to the following:

MVP Health Plan, Inc. is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan.**

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or through my employer group.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP 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 MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. MVP's Medicare Advantage plans offer worldwide coverage for emergency care.

I understand that beginning on the date MVP coverage begins, I must get all of my health care from MVP, except for emergency or urgently needed services, or out-of-area dialysis services. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor MVP will pay for these services.

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

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Medicare Advantage Health Plans
Employer Group Enrollment with Part D Application

Please complete Steps 1–6. Complete one enrollment application per applicant.

Step 1: Plan Enrollment Selection for Employer Group or Union Member *(Please print)*

Employer or Union Name | Group No. | Date Coverage to Begin

Please select which employer group plan you are enrolling in:

☐ **MVP Preferred Gold HMO-POS with Part D** prescription drug coverage | Product ID No. | Subgroup No.

☐ **MVP® USA Care PPO® with Part D** prescription drug coverage | Product ID No. | Subgroup No.

Step 2: Provide Information About Yourself *(Please print)*

Name *(last, first, middle initial)* | Gender ☐ Male ☐ Female | Date of Birth

Permanent Residence Street Address *(PO Box is not allowed)* | Preferred Phone No. ( )

City | State | Zip Code | County

Mailing Address *(if different from Permanent Address)* | City | State | Zip Code

Email Address *(optional)*

Step 3: Provide Your Medicare Insurance Information

Using your Medicare card, fill in these blanks so they match your red, white, and blue Medicare card. Or attach a copy of your Medicare card, or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card) | Medicare Number

Is Entitled To:

Hospital (Part A) Effective Date | Medical (Part B) Effective Date

Y0051_5929_C MVPforms0066 (10/2021)

Step 4: Provide the Name of Your Primary Care Physician (PCP)

Complete this Step only if you are enrolling in Preferred Gold HMO-POS plan.

PCP's Full Name | Are you an existing patient? ☐ Yes ☐ No

Step 5: Read and Provide Answers to the Following Questions *(Please print)*

1. Are you the retiree? ☐ **Yes** Your retirement date *(MM/DD/YYYY)* _____ ☐ **No** Name of retiree _____
2. Are you covering a spouse or dependent(s) under this employer or union plan? ☐ **Yes** Name of spouse _____ ☐ **No** Name(s) of dependent(s) _____
3. Do you or your spouse work? ☐ **Yes** ☐ **No**
4. Will you have other prescription drug coverage in addition to MVP? ☐ **Yes** ☐ **No**
   Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, EPIC (NY), or V-Pharm (VT).
   If ***Yes***, refer to the ID card for your other drug coverage and provide the following:
   Name of Other Coverage | Effective Date
   Rx ID No. | Rx Group No. | Rx BIN No. | Rx PCN
5. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**
   If ***Yes***, provide the following information about the facility:
   Name of Institution | Street Address | Phone No. ( )
6. Have you served in the military? ☐ **Yes** ☐ **No**

Please contact the MVP Medicare Customer Care at **1-800-665-7924** if you need information in a language other than English, or in an accessible format. Call seven days a week, 8 am–8 pm. April 1–September 30, call Monday–Friday, 8 am–8 pm. TTY: 1-800-662-1220.

Step 6: Read the Following, and Provide Your Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent to the release, use, and disclosure of my information (which may include prescription information, medical information, HIV, mental health, and /or alcohol and substance abuse information) by MVP or any health care provider involved in caring for me to Medicare,MVP, or any health care providers, or organizations involved in my care, and other plans as is reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. I also acknowledge that MVP may release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. 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.

By providing my email address, I give permission for MVP to send me emails related to my plan and benefits. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences* or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State 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 from Medicare.

Please sign below.

Signature **Today's Date**

If you are the authorized representative, you must sign above and provide the following information about yourself.

Name | Relationship to Enrollee

Address | Preferred Phone No. ( )

Office Use Only

Name of Staff Member/Agent/Broker *(If assisted in enrollment)* | Plan ID No. | Effective Date of Coverage

ICEP/IEP | AEP | SEP (type) | Not Eligible | Agent License No.

Forms and Letters Reference

Actively Employed Information Form

Actively Employed Information

Subscriber: Take this form to the MVP Health Care® (MVP) plan subscriber's employer and complete it together. For the most up-to-date information and accuracy of our records, **please return the completed form to MVP within the month of the member turning 65**.

Employer: Complete this form if the subscriber will continue working past age 65, or if the subscriber will continue to work and cover his/her spouse or domestic partner who is turning 65.

By completing this form, you, the employer, are validating that:

- Your company employs **20 or more people**.
- The subscriber who carries the MVP Health Care policy is not retiring and will continue to work for you as an active employee past age 65, or will continue to work when his/her spouse/domestic partner turns 65.
- You will continue to provide the same health benefits under the same conditions to Medicare eligible employees and the Medicare eligible spouses/domestic partners of employees, as you provide to employees and spouses/domestic partners who are not Medicare eligible. You are required to notify MVP upon retirement of the employee.

Section 1: Group and Subscriber Information

Group Name		**Group** No.
Group Representative Signature	Signature Date	**Group** Phone No. ( )

☐ I certify that the employee listed below is actively working for the group named above.

Employee/MVP Subscriber's Name	Date of Birth
Employee/MVP Subscriber's Member ID No.	

Section 2: Information About Individual Turning Age 65

Name of Individual Turning Age 65

Who is turning age 65? ☐ Employee/MVP Subscriber ☐ Spouse ☐ Domestic Partner

If this person is electing Medicare at this time, complete Section 3.

Section 3: Medicare Election

Medicare Part A (Hospital) Effective Date	Medicare Part B (Medical) Effective Date
If Not Eligible for Part A, Explain Why	Medicare Health Insurance Claim No.

Please return this completed form by mail to:

ATTN: COORDINATION OF BENEFITS, MVP HEALTH CARE, PO BOX 2207, SCHENECTADY NY 12301-9884

Y0051_5283_C MVPform0139 (02/2021)

Forms and Letters Reference

Health and Wellness Assessment Survey

(Continued on page 22)

MVP HEALTH CARE

Please return the questionnaire to:

Health Services Research
MVP Health Care
PO BOX 10054
TOLEDO, OH 43682-4404

Health & Wellness Assessment Survey

1. In general, how would you rate your overall health?
   1 O Excellent
   2 O Very good
   3 O Good
   4 O Fair
   5 O Poor
2. In the past 12 months, how many times have you stayed overnight as a patient in a hospital?
   1 O Never
   2 O 1 time
   3 O 2 to 3 times
   4 O 4 or more times
3. In the past 12 months, how many times have you visited a physician or clinic?
   1 O Never
   2 O 1 time
   3 O 2 to 3 times
   4 O 4 to 6 times
   5 O 7 or more times
4. In the past 12 months, have you been told by a doctor that you have diabetes or are you being treated for diabetes?
   1 O Yes
   2 O No
5. Have you ever had coronary artery disease (hardening of the arteries)?
   1 O Yes
   2 O No
6. Have you ever had pains associated with the heart and chest (angina pectoris)?
   1 O Yes
   2 O No
7. Have you ever had a heart attack or myocardial infarction?
   1 O Yes
   2 O No
8. Have you ever had any other heart conditions such as problems with heart valves or the rhythm of your heartbeat?
   1 O Yes
   2 O No
9. Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?
   1 O Yes
   2 O No

Survey ID 6011001

PHYSICAL ACTIVITY

10. On average, how many **days per week** do you do cardiovascular exercises such as jogging, cardio machines, aerobics, brisk walking, or swimming for at least 30 minutes to the point where (1) your heart and breathing rate increases, and (2) you start to sweat but you can still talk.
    1 O I do not exercise regularly
    2 O Less than 1 day per week
    3 O 1 to 2 days per week
    4 O 3 to 4 days per week
    5 O 5 or more days per week
11. On average, how many **days per week** do you do strength-building exercises, including weightlifting, push-ups, sit-ups, yoga, Pilates, or any other such exercise?
    1 O I do not exercise regularly
    2 O Less than 1 day per week
    3 O 1 to 2 days per week
    4 O 3 to 4 days per week
    5 O 5 or more days per week
12. How much difficulty, on average, do you have with **stooping, crouching or kneeling**?
    1 O Unable to do
    2 O A lot of difficulty
    3 O Some difficulty
    4 O A little difficulty
    5 O No difficulty
13. How much difficulty, on average, do you have with **lifting or carrying objects as heavy as 10 pounds**?
    1 O Unable to do
    2 O A lot of difficulty
    3 O Some difficulty
    4 O A little difficulty
    5 O No difficulty
14. How much difficulty, on average, do you have with **reaching or extending arms above shoulder level**?
    1 O Unable to do
    2 O A lot of difficulty
    3 O Some difficulty
    4 O A little difficulty
    5 O No difficulty
15. How much difficulty, on average, do you have with **writing, or handling and grasping small objects**?
    1 O Unable to do
    2 O A lot of difficulty
    3 O Some difficulty
    4 O A little difficulty
    5 O No difficulty
16. How much difficulty, on average, do you have with **doing heavy housework such as scrubbing floors or washing windows**?
    1 O Unable to do
    2 O A lot of difficulty
    3 O Some difficulty
    4 O A little difficulty
    5 O No difficulty
17. During the past 30 days, how much did **pain** interfere with any work outside the home or day to day activities such as housework?
    1 O Not at all
    2 O A little bit
    3 O Somewhat
    4 O Quite a bit
    5 O Very much

Survey ID 6011002

18. In the past 7 days, how would you rate your pain on average?
    O 0 – No pain
    O 1
    O 2
    O 3
    O 4
    O 5
    O 6
    O 7
    O 8
    O 9
    O 10 – Worst imaginable pain
19. Has your doctor or other health provider ever talked with you about the benefits of aspirin to prevent heart attack or stroke?
    1 O Yes
    2 O No
20. Do you now take aspirin daily or every other day?
    1 O Yes
    2 O No

HEALTHY LIFESTYLES

21. Are you male or female?
    1 O Male → **GO TO QUESTION 24**
    2 O Female → **GO TO QUESTION 22**
22. A mammogram is an x-ray of each breast to look for breast cancer. In the past 2 years, have you had a mammogram?
    1 O Yes
    2 O No
23. A Pap smear, also called a Pap test, is a procedure to test for cervical cancer in women. How long has it been since you had your last Pap smear or Pap test?
    1 O Within the past 1 year
    2 O Within the past 3 years
    3 O 4 or more years ago
24. Have you ever been checked for colon cancer by a doctor, either through (1) stool testing for blood within the last year, or (2) a sigmoidoscopy with the last 5 years, or (3) a colonoscopy within the last 10 years?
    1 O Yes
    2 O No
25. In the past 7 days, on how many days did you have 5 or more servings of fruits and vegetables?
    1 O Don't Know / Unsure
    2 O 0 days / Never
    3 O 1 to 2 days
    4 O 3 to 4 days
    5 O 5 to 7 days
26. On an **average day**, how many alcoholic drinks do you usually consume?

1 drink =	1 bottle of beer or wine cooler (12 ounces)
	1 glass of wine (5 ounces)
	1 shot of 80-proof distilled spirits (1.5 ounces)

    1 O None
    2 O 1 drink
    3 O 2 drinks
    4 O 3 drinks
    5 O 4 or more drinks

Survey ID 6011003

27. How often do you wear your seatbelt when driving or riding in a car or truck?
    1 O Never
    2 O Sometimes
    3 O Usually
    4 O Always
28. Do you now smoke cigarettes or use tobacco (chew or snuff) every day, some days or not at all?
    1 O Every day
    2 O Some days
    3 O Not at all → **GO TO QUESTION 31**
    4 O Don't know → **GO TO QUESTION 31**
29. Have you ever thought about quitting smoking?
    1 O Yes
    2 O No
30. Have you ever talked with a doctor about things you can do to quit smoking?
    1 O Yes
    2 O No
31. During the past 30 days, did you **accomplish less than you would like** with your work or other regular daily activities as a result of your health or **physical condition**?
    1 O No, not at all
    2 O Yes, a little of the time
    3 O Yes, some of the time
    4 O Yes, most of the time
    5 O Yes, all of the time
32. During the past 30 days, were you limited in the **kind** of work or other regular daily activities as a result of any **health or physical condition**?
    1 O No, not at all
    2 O Yes, a little of the time
    3 O Yes, some of the time
    4 O Yes, most of the time
    5 O Yes, all of the time
33. During the past 30 days, were you limited in the **kind** of work or other regular daily activities as a result of any **mental or emotional condition** (such as feeling depressed or anxious)?
    1 O No, not at all
    2 O Yes, a little of the time
    3 O Yes, some of the time
    4 O Yes, most of the time
    5 O Yes, all of the time
34. During the past 30 days, did you not do work or other daily activities as carefully as usual due to any **mental or emotional condition** (such as feeling depressed or anxious)?
    1 O No, not at all
    2 O Yes, a little of the time
    3 O Yes, some of the time
    4 O Yes, most of the time
    5 O Yes, all of the time

YOUR FEELINGS IN THE PAST 2 WEEKS

35. Over the past 2 weeks, how often have you felt **little interest or pleasure in doing things**?
    1 O Not at all
    2 O Several days
    3 O More than half the days
    4 O Nearly everyday
36. Over the past 2 weeks, how often have you felt **down, depressed or hopeless**?
    1 O Not at all
    2 O Several days
    3 O More than half the days
    4 O Nearly everyday

Survey ID 6011004

Forms and Letters Reference

Health and Wellness Assessment Survey

(Continued from page 21)

37. In the last month, how often have you felt **nervous and "stressed"**?
    - 1 O Never
    - 2 O Almost Never
    - 3 O Sometimes
    - 4 O Fairly Often
    - 5 O Very Often

38. In the last month, how often have you **felt confident** about your ability to handle your personal problems?
    - 1 O Never
    - 2 O Almost Never
    - 3 O Sometimes
    - 4 O Fairly Often
    - 5 O Very Often

39. In the last month, how often have you been **angered** because of things that were outside of your control?
    - 1 O Never
    - 2 O Almost Never
    - 3 O Sometimes
    - 4 O Fairly Often
    - 5 O Very Often

40. In general, how strong are your social ties with your family and/or friends?
    - 1 O Very strong
    - 2 O About average
    - 3 O Weaker than average
    - 4 O Not sure

41. Over the last **two weeks**, how often have you **felt isolated from others**?
    - 1 O Not at all
    - 2 O Several days
    - 3 O More than half the days
    - 4 O Nearly every day

Survey ID 6011005

42. For each of the activities listed below, please indicate if you are: (1) able to do this without help, (2) need some help, or (3) cannot do this at all without help.

	Able to do this without help	Need some help	Cannot do this at all without help
Bathing or showering	O	O	O
Dressing	O	O	O
Eating	O	O	O
Walking	O	O	O
Climbing stairs	O	O	O
Getting in and out of bed or chairs	O	O	O
Grooming	O	O	O
Brushing your teeth	O	O	O
Using the toilet	O	O	O
Able to do this without help	**Need some help**	**Cannot do this at all without help**	
Using the telephone	O	O	O
Driving	O	O	O
Grocery shopping	O	O	O
Preparing meals or cooking	O	O	O
Doing housework or handyman work	O	O	O
Doing laundry	O	O	O
Taking and managing medications	O	O	O
Money management	O	O	O

43. Do you have any vision problems that require special reading materials or equipment?
    - 1 O Yes
    - 2 O No

44. Are you deaf or do you have serious difficulty hearing?
    - 1 O Yes
    - 2 O No

45. Does your home have any of the following home safety items?

	Yes	No
a. Grab bars in the bathroom	O	O
b. Security system for falls / emergency alert	O	O
c. Smoke detectors	O	O
d. Carbon monoxide detectors	O	O

Survey ID 6011006

ABOUT YOU

46. Has a doctor ever told you that you have any of the following conditions? **(CHECK ALL THAT APPLY)**
    - 1 O Allergies
    - 2 O Arthritis / Rheumatism
    - 3 O Asthma
    - 4 O COPD, or emphysema
    - 5 O Chronic Bronchitis
    - 6 O Chronic back pain
    - 7 O Chronic insomnia or sleep disorder
    - 8 O Congestive heart failure
    - 9 O Crohn's disease, ulcerative colitis, or inflammatory bowel disease
    - 10 O Cancer
    - 11 O Depression
    - 12 O End Stage Renal Disease (ESRD)
    - 13 O High cholesterol
    - 14 O Hypertension / High blood pressure
    - 15 O Lung disease
    - 16 O Memory loss
    - 17 O Osteoporosis
    - 18 O Sciatica (pain / numbness that travels down your leg to below your knee)
    - 19 O Stomach ulcer or peptic ulcer
    - 20 O Stroke / Transient Ischemic Attack (TIA)
    - 21 O Swelling of your ankles or legs
    - 22 O Urinary problems (urine leakage)
    - 23 O Other:_____
    - 24 O NONE

47. Have you received a flu (influenza) shot within the past year?
    - 1 O Yes
    - 2 O No

48. What is the highest grade or level of school that you have completed?
    - 1 O 8th grade or less
    - 2 O Some high school, but did not graduate
    - 3 O High school graduate or GED
    - 4 O Some college or 2-year degree
    - 5 O 4-year college graduate
    - 6 O More than 4-year college degree

49. In what year were you born?

1	9		

50. How much do you weigh in pounds (lbs.)?

			Lbs.

51. How tall are you without shoes on in feet (ft.) and inches (in.)? Please fill in BOTH feet and inches (e.g., 5 ft. 00 in.) If ½ inch, please round up.

	Feet			In.

52. Are you of Hispanic or Latino origin or descent?
    - 1 O Yes, Hispanic or Latino
    - 2 O No, not Hispanic or Latino

53. What is your race? Mark one or more.
    - 1 O White
    - 2 O Black or African American
    - 3 O Asian
    - 4 O Native Hawaiian or Other Pacific Islander
    - 5 O American Indian or Alaskan Native
    - 6 O Other

Survey ID 6011007

54. Do you live alone or with others?
    - 1 O Alone
    - 2 O With spouse / significant other
    - 3 O With children / other relatives
    - 4 O With non-relatives or paid caregiver

55. Where do you live?
    - 1 O Independent house, apartment, condominium, or mobile home
    - 2 O Assisted living apartment or board and care home
    - 3 O Nursing home
    - 4 O Other: _____

56. What language do you speak most of the time at home?
    - 1 O English
    - 2 O Spanish
    - 3 O Italian
    - 4 O German
    - 5 O Other: _____

Survey ID 6011008