

# Employer Handbook

For MVP Medicare Advantage Health plans





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# Employer Handbook

## For MVP Medicare Advantage Health Plans

### Introduction

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, accurate information makes managing your retiree benefits simpler.

This handbook has been updated to include the latest information to help you manage your MVP Medicare Advantage health plans. You will find information on:

- Medicare
- Eligibility requirements for Medicare and MVP Medicare Advantage plans
- Overview of the enrollment and billing process
- Answers to commonly asked questions

Please note that the information in this handbook was correct at the time of publication. Updates will be published as necessary.

### 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). However, they may not join a Medicare Advantage plan unless they were covered previously through a commercial plan with the same company when they developed ESRD, OR MVP has exclusive coverage for an employer.

#### 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% coinsurance. Members continue to pay the Part B premium monthly out of their Social Security check.

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 (Health Maintenance Organization) the primary care physician coordinates the member's health care. The benefits available under an HMO are usually better than those available under Original Medicare.

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. A PPO gives the member the choice of receiving services within the participating provider network or outside of the provider network. The cost to the member will be more for services provided outside of the PPO's provider network. Residency requirements vary based on product.

### **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 stand-alone 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 plan with prescription drugs, the person is enrolled in Medicare Part D.

## Medicare Advantage HMOs and PPOs

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. Any additional premium paid by an employer or individual covers the cost of additional services such as routine eye exams.

## 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.
- 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 prior to enrolling, unless:
  - They developed ESRD while enrolled as an MVP commercial health plan member.
  - Are diagnosed after the date of signature on the enrollment form.
  - If an employer group converts to MVP Health Care exclusively.

## Frequently asked eligibility questions

**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.

## 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. 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 out 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.

**Our 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 signature on the enrollment form must be dated prior to the effective date.**

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

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

## Frequently asked 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 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.

### **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 employer group service area (except for 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 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 term the member.

## Age-in process

Monthly reports are sent to employers listing their members who are turning age 65 in 90 days. This allows the employer group to know who will receive Medicare enrollment information.

Members turning 65 are sent a packet that explains the plan coverage appropriate to the member, based on the Medicare Advantage plan offered through the employer. If the employer does not offer an MVP Medicare Advantage plan, the member is eligible to enroll in an MVP Medicare Advantage individual bill plan.

Three notifications are made beginning 90 days prior to Medicare eligibility. If the member does not respond to any of the above notifications, the employer will be contacted in a timely manner to determine whether the member should be left in the employer's commercial benefit plan.

## Frequently asked age-in processing questions

**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.

**Q: What if a member continues to work after age 65?**

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 Section titled "Medicare Secondary Payer" for more information.

## Enrollment form completion instructions

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 should be sent to:

MVP Health Care  
Medicare Enrollment  
220 Alexander St.  
Rochester, NY 14607

Fax: 1-585-327-2227

Email: [goldenrollment@mvphealthcare.com](mailto:goldenrollment@mvphealthcare.com)

### 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

### ***Section 1: Plan enrollment selection for employer groups or union members***

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

### **Section 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.

### **Section 3: Medicare card information**

1. Review the retiree's red, white and blue Medicare card.
2. Fill out the retiree's name exactly as it appears on the Medicare card.
3. Fill in the Medicare claim number.
4. Fill in 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.

### **Section 4: Primary care physician (PCP)**

Each retiree and spouse enrolled in the Preferred Gold HMO plan must choose a primary care physician (PCP) within the MVP provider network. Retirees enrolled in the GoldAnywhere PPO plan or 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 found at [www.mvphealthcare.com](http://www.mvphealthcare.com).

1. Enter the PCP's full name. Note: 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.

### **Section 5: "Please read and answer these important questions"**

Each of the questions in this section must be answered.

### **Section 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 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 MVP's "Attestation of Creditable Coverage" – see Exhibit 1 in the Attachments section at the end of this handbook.

## Member ID cards

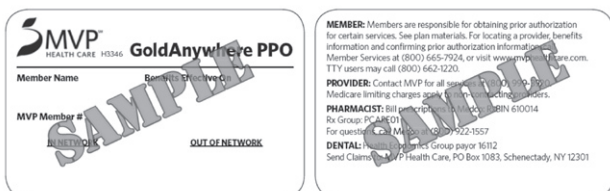
The following are sample Preferred Gold HMO member ID cards:



or



The following are sample GoldAnywhere PPO member ID cards:



or



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

Member ID cards do not have an end date. Members whose coverage and copays do not change from year to year will be able to continue using the same card. Member cards are not automatically reissued on a yearly basis if the information on the card (e.g., copays, PCP, 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 member portal on the MVP Health Care Web site.

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

## Medco ID card

Here is a sample Medco member ID card:



Retirees in an MVP Medicare Advantage plan with a prescription drug rider will receive a separate Medco prescription drug card in addition to their MVP medical plan card. The Medco card will be received about two weeks after CMS approves the retiree enrollment. Retirees must present their Medco card to obtain prescriptions at the pharmacy.

## 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 MVP's 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 later enrollment penalty if they do not enroll in other coverage within 63 days.

### **Disenrollment notification can be sent to:**

MVP Health Care  
Medicare Advantage Enrollment  
220 Alexander St.  
Rochester, NY 14607

Fax: 1-585-327-2227

Email: [goldenrollment@mvphealthcare.com](mailto:goldenrollment@mvphealthcare.com)

### **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.

**CAUTION:** If the member is enrolling in another Medicare Advantage plan, DO NOT complete a disenrollment form. Enrollment in the other Medicare Advantage plan will automatically trigger the disenrollment.

## 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 you allow this:

- Medicare is still primary.
- We 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 it.

## COBRA questions and answers

### **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 (SEP) 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 SEP, 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 of Coverage under COBRA” at <http://www.dol.gov/ebsa/pdf/cobraemployer.pdf>.

## 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 MSP can be accessed at: <http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019017&intNumPerPage=10>

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 aged 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 eligible for the employer's health plan.

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 (SEP) 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.

**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 MSP 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?

Here is a summary of which plan is primary in specific situations:

Number of full time employees	Member status	Who is primary?
Under 20	Active employee or dependent	Medicare
Under 20	Retired employee or dependent	Medicare
Over 20	Active employee or dependent	Commercial plan
Over 20	Retired employee or dependent	Medicare
Under 100	Disabled active employee or dependent of an active employee	Medicare
Under 100	Disabled retired employee or dependent of a retired employee	Medicare
Over 100	Disabled active employee or dependent of an active employee	Commercial plan
Over 100	Disabled retired employee or dependent of a retired employee	Medicare

More information is available in the CMS publication of “Who Pays First” at <http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf>.

## Premium invoice

### Information on your invoice

Your premium invoice is based on your group's enrollment information at the time the invoice is produced. MVP Medicare Advantage plan invoicing will be separate from your commercial group invoice.

The invoice will reflect all additions, terminations and changes received at least four (4) 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. Please also see the Low Income Subsidy section describing the subsidy classifications.

### Reconciling and making adjustments to your invoice

Reconciling your invoice each month will help you confirm the accuracy of your payment. Full payment of the invoice amount is expected unless you note discrepancies with your payment.

Check your invoice before sending in your payment to make sure you are being billed for the correct retirees. Your invoice will give you all the information you need to compare your records to ours.

Your invoice will list each retiree's name, contract number and effective date.

Mail payments to the address noted on the invoice.

## Dual eligibles – full / partial and Low Income Subsidy benefit descriptions

### **Full Benefit Dual Eligibles (FBD)**

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 copay for Part D drugs. Individuals not residing in an institution, but who are Full Benefit Dual Eligible, may have a small copay 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 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 (LIS)**

Retirees may qualify for a subsidy for Medicare Part D based on their income/assets. The subsidy provides assistance with the premium, deductible and copayments of the Part D program. Retirees may apply for the Low Income Subsidy with the Social Security Administration or with the NYS Medicaid agency.

CMS will notify MVP if any of your retirees are eligible for a Low Income Subsidy. Upon notification, MVP is mandated by CMS to enroll these retirees into the appropriate Low Income Subsidy level, which will appear with a reduced premium on your billing statement.

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

### **Late Enrollment Penalty (LEP)**

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. LEP penalty 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.

If your retirees have questions about their health care coverage, they may contact MVP's Medicare Customer Care Center at the phone numbers on the back of their MVP member ID cards.

### **Representatives are available as follows:**

Through March 1, 2011, call seven days a week from 8 am - 8 pm Eastern Time.

Beginning March 2, 2011, new Customer Care Center hours will be Monday - Friday, 8 am - 8 pm, and Saturday, 8 am - 4 pm.

**Members living in Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming and Yates counties should call:**

1-800-665-7924  
TTY: 1-800-662-1220

**Members living in all other New York state counties should call:**

1-800-209-3945  
TTY: 1-800-662-1220

MVP Health Care Web site:  
[www.mvphealthcare.com](http://www.mvphealthcare.com)

### **Medicare (CMS)**

1-800-MEDICARE  
TTY: 1-877-486-2048

Medicare Web site:  
[www.medicare.gov](http://www.medicare.gov)



## 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 (e.g., EPIC); 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.

\_\_\_\_\_  
Group Name:

\_\_\_\_\_  
Group Number:

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative Name and Title *(Please Print)*

<SYSDATE>

**Re: Acknowledge Receipt of Completed Enrollment Request**

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

<ADDRESS-1>

<ADDRESS-2>

<CITY;;; STATE ZIP>

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

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must see your <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 <plan name> doctor(s). You will need to pay your plan co-payments and coinsurance at the time you get health care services as described in your member materials. **[Optional language:** This letter is proof of insurance that you should show at your doctor appointments until you get your member card from us.] **[Optional language for 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 PPO plans use the following paragraph in place of 1st paragraph above:**

Thank you for enrolling in <Plan name>. Beginning <effective date>, you must get your health care as provided in your <insert either „Member handbook “ or „Evidence of Coverage “>. You will need to pay your plan co-payments and co-insurance at the time you get health care services, as described in your member materials. **[Optional language:** This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.]

**What should I do now?**

Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <plan name>. But, you shouldn't wait to get this letter before you begin using <plan name> doctors on <effective date>. Also, don't cancel any Medigap/Medicare Select or supplemental insurance that you have until we send you the confirmation letter.

**What do I need to know about getting health care services?**

You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of <Plan>. If you don't have Medicare Parts A and B, we will bill you for any health care you receive from us, and neither Medicare nor <plan name> will pay for those services. Also, if you have end stage renal disease (ESRD), you may not be able to be a member of <plan name>, and we may have to send you a bill for any health care you've received.

**[MA PPO plans do not use the following paragraph:** Please remember that, except for emergency or out-of-area urgent care, or out-of-area dialysis services, if you get

<Contract#, Y0051\_0491, Exhibit 4, 09/16/2010>

health care services from a non-<plan name> doctor without prior authorization, you will have to pay for these services yourself.]

*[MA-PD plans with a premium include the following two paragraphs:*

**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 eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office or call 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](http://www.socialsecurity.gov/prescriptionhelp).]

If you have any questions, please call Member Services at:

**<Phone#. TTY users call 1-800-662-1220.**

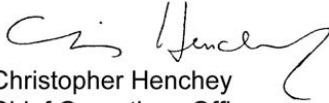
**Representatives are available to serve you:** Monday-Friday 7am – 8pm Eastern Time.

**November 15, 2010 – March 1, 2011** call every day, 8am – 8pm.

**Beginning March 2, 2011, new Member Services hours will be:**

Monday – Friday, 8am – 8pm, Saturday 8am – 4pm.>

Sincerely,



Christopher Henchey  
Chief Operations Officer

<Member # >

<RxGroup>

<RxBin>

<RxPCN>

<Contract#, Y0051\_0491, Exhibit 4, 09/16/2010>

<SYSDATE>

**Re: Receipt of Completed Enrollment Request –  
Enrollment in another Plan Within the Same Parent  
Organization**

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

<ADDRESS-1>

<ADDRESS-2>

<CITY;;; STATE ZIP>

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

Thank you for your request to change your enrollment with MVP Health Care. Starting <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 copayments at the time you get health care services. [*Optional*: This letter is proof of health insurance that you should show during your doctor appointments.] [**Optional language for 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 PPO plans use the following paragraph in place of 1st paragraph above:**

Thank you for your request to change your enrollment from <old plan name> to <new plan name>. Beginning <effective date>, you must get your health care as provided in your <insert either „Member handbook “ or „Evidence of Coverage “>. You will need to pay your plan co-payments and coinsurance at the time you get health care services, as provided in your member materials.

<*Optional*: This letter is proof of insurance that you should show during your doctor appointments until you get your member card from us.>] [**Optional language for 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.]

**What should I do now?**

Medicare must review all enrollments. We will send your enrollment to Medicare, and they will do a final review. When Medicare finishes its review, we will send you a letter to confirm your enrollment with <new plan name>. But, you shouldn't wait to get this letter before you begin using <new plan name> doctors on <effective date>.

**[MA PPO plans do not use the following sentence:** 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- <new plan name> doctor without prior authorization, you will have to pay for these services yourself.]

If you have any questions, please call Member Services at:

**<Phone#. TTY users call 1-800-662-1220.**


**Representatives are available to serve you:** Monday-Friday 7am – 8pm Eastern Time.  
**November 15, 2010 – March 1, 2011** call every day, 8am – 8pm.

<Contract#, Y0051\_0492, Exhibit 4a, 09/16/2010>

**Beginning March 2, 2011, new Member Services hours will be:**

Monday – Friday, 8am – 8pm, Saturday 8am – 4pm.>

Sincerely,



Christopher Henchey  
Chief Operations Officer

<Member # >

<RxGroup>

<RxBin>

<RxPCN>

<Contract#, Y0051\_0492, Exhibit 4a, 09/16/2010>

<SYSDATE>

**Re: Notice to Confirm Enrollment (MA-PD)**

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

<ADDRESS-1>

<ADDRESS-2>

<CITY;;; STATE ZIP>

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

Please be sure to keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.

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](http://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> at the phone number provided at the end of this letter.

*[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:

- <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> at the phone number provided at the end of this letter.]

<Contract#, Y0051\_0494, Exhibit 6, 09/16/2010>

**What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?**

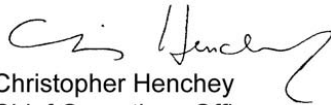
Now that we have confirmed your enrollment, you may cancel any Medigap policy or supplemental insurance that you have. Please note that if this is the first time that you are a member of a Medicare Advantage or Medicare Cost plan, you may have certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) for further information about Medigap policies. TTY users should call 1-877-486-2048.

If you have any questions, please call Member Services at:  
**<Phone#. TTY users call 1-800-662-1220.**

**Representatives are available to serve you:** Monday-Friday 7am – 8pm Eastern Time.  
**November 15, 2010 – March 1, 2011** call every day, 8am – 8pm.

**Beginning March 2, 2011, new Member Services hours will be:**  
Monday – Friday, 8am – 8pm, Saturday 8am – 4pm.>

Sincerely,



Christopher Henchey  
Chief Operations Officer

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

<Contract#, Y0051\_0494, Exhibit 6, 09/16/2010>

<SYSDATE>

**Re: Notice to Confirm Enrollment - Plan to Plan Within  
Parent Organization**

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

<ADDRESS-1>

<ADDRESS-2>

<CITY;;; STATE ZIP>

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

Please keep a copy of this letter for your records. Medicare has approved your enrollment in <plan name> beginning <effective date>.

For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.

**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](http://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 call <plan name> at the phone number provided at the end of this letter.

*[MA-PD, 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:

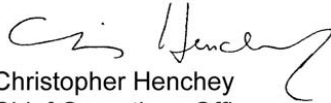
- <insert appropriate LIS deductible amount> for your yearly prescription drug plan deductible,
- <insert appropriate LIS copay amount> copayment when you fill a prescription covered by <plan name>.

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

<Contract#, Y0051\_0495, Exhibit 6a, 09/16/2010>

If you have any questions, please call Member Services at:  
**<Phone#. TTY users call 1-800-662-1220.**  
**Representatives are available to serve you:** Monday-Friday 7am – 8pm Eastern Time.  
**November 15, 2010 – March 1, 2011** call every day, 8am – 8pm.  
**Beginning March 2, 2011, new Member Services hours will be:**  
Monday – Friday, 8am – 8pm, Saturday 8am – 4pm.>

Sincerely,



Christopher Henchey  
Chief Operations Officer

<Member # >

<RxGroup>

<RxBin>

<RxPCN>

<Contract#, Y0051\_0495, Exhibit 6a, 09/16/2010>

<SYSDATE>

**Re: Notice to Confirm Enrollment (MA-only)**

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

<ADDRESS-1>

<ADDRESS-2>

<CITY;;; STATE ZIP>

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

Thank you for enrolling in <plan name>. Medicare has approved your enrollment in <plan name> beginning <effective date>. Please be sure to keep a copy of this letter for your records.

**What if I have a Medigap (Medicare Supplement Insurance) policy or other supplemental insurance?**

Now that we have confirmed your enrollment, you may cancel any Medigap policy 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 certain rights to **leave** (disenroll from) <plan name> and buy a Medigap policy. Please contact 1-800-MEDICARE (1-800-633-4227) for further information about Medigap policies. TTY users should call 1-877-486-2048.

If you have any questions, please call Member Services at:

**<Phone#. TTY users call 1-800- 662-1220.**

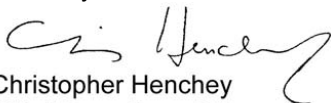
**Representatives are available to serve you:** Monday - Friday, 7am – 8pm Eastern Time.

**November 15, 2010 – March 1, 2011** call every day, 8am – 8pm.

**Beginning March 2, 2011, new Member Services hours will be:**

Monday – Friday, 8am – 8pm, Saturday 8am – 4pm.>

Sincerely,



Christopher Henchey  
Chief Operations Officer

<Member # >

<Contract#, Y0051\_0497, Exhibit 6d, 09/16/2010>



## Medicare Advantage Health Plans Enrollment Application & Part D Application EMPLOYER GROUP

---

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

MVP 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 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: Annual Enrollment Period from October 15 - December 7); 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.

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 THE 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.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.



Please complete both pages.  
Complete one enrollment form per applicant.

**Section 1: Plan enrollment selection for employer group or union members**

Employer or union name \_\_\_\_\_ Group # \_\_\_\_\_

Please check which plan you want to enroll in:

- Preferred Gold HMO with MVP Part D Prescription Drug
- GoldAnywhere PPO with MVP Part D Prescription Drug
- USA Care PPO with MVP Part D Prescription Drug
- Preferred Gold HMO without MVP Part D Prescription Drug

**Section 2: Member information**

LAST Name \_\_\_\_\_ FIRST Name \_\_\_\_\_ Mid. Init. \_\_\_\_\_

Permanent Street Address (P.O. Box is not allowed) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ County \_\_\_\_\_

Home Phone Number ( ) \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  M  F

Mailing Address (only if different from your permanent residence address)

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

**Section 3: Medicare card information**

Please take out your Medicare card to complete this section.

- Please 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.

**Medicare Health Insurance**

Name \_\_\_\_\_ Medicare Claim # \_\_\_\_\_

Is Entitled To: Hospital (Part A) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Medical (Part B) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Section 4: Primary Care Physician (PCP) - not required for GoldAnywhere PPO or USA Care PPO**

Primary Care Physician (full name required) \_\_\_\_\_

Existing patient?  Yes  No

FOR EMPLOYER GROUP AND MVP USE

**Section 5: Please read and answer these important questions**

1. Are you the retiree?  Yes  No  
 If yes, retirement date (*month/day/year*) \_\_\_\_\_ If no, name of retiree \_\_\_\_\_
2. Are you covering a spouse or dependents under this employer or union plan?  Yes  No  
 If yes, name of spouse \_\_\_\_\_  
 Names of dependents \_\_\_\_\_
3. Do you or your spouse work?  Yes  No
4. Do you have End Stage Renal Disease (ESRD)?  Yes  No  
 If you answered yes to this question and you don't need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.
5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs (EPIC).  
 Will you have other prescription drug coverage in addition to MVP?  Yes  No  
 If yes, name of other coverage \_\_\_\_\_  
 ID # for coverage \_\_\_\_\_

**Your answer to the following question will not keep you from enrolling in this plan.**

6. Are you a resident in a long term care facility, such as a nursing home?  Yes  No  
 If yes, please provide the following information:  
 Name of Institution: \_\_\_\_\_  
 Address & phone number of Institution (number and street): \_\_\_\_\_

**Section 6: Signature and Authorization**

**Release of information:** By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MVP will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under 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 by MVP or by Medicare.

**PLEASE SIGN BELOW**

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

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

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship to Enrollee \_\_\_\_\_

**FOR EMPLOYER GROUP AND MVP USE**

Exhibit 3: Sample Employer Group Enrollment Form

**Please contact MVP if you need information in another language or format (Braille).**

Our office hours are:  
Monday - Friday, 8 am - 5 pm Eastern Time  
From November 15 - March 1,  
representatives are available every day from 8 am - 8 pm

**1-888-280-6205**  
**TTY: 1-800-662-1220**

**For Office Use Only**

<b>Enter in:</b> <input type="checkbox"/> <b>Amisys</b> <input type="checkbox"/> <b>Facets</b>	If current member, please include member ID number: A OR 8		
Previous ID # _____	Group Name _____	Group # _____	
Effective Date Requested _____	Input Date _____	Initials _____	
<input type="checkbox"/> ICEP/IEP	<input type="checkbox"/> AEP	<input type="checkbox"/> SEP (type): _____	Not eligible: _____
<b>Date coverage should begin: ____/____/____ (employer group use only)</b>			
Name of staff member/agent/broker (if assisted in enrollment): _____			

M501047

SCH



## Medicare Advantage Health Assessment Survey

NAME  
ADDRESS 1  
ADDRESS 2  
CITY STATE ZIP

Dear Member:

Thank you for your membership in MVP Health Care. At MVP we want to make sure you are getting the best health care possible. One way we do this is by getting to know you and helping you meet your unique health care needs.

Please help us with your health care by answering the following survey. There are no right or wrong answers. If you are not able to complete this survey by yourself, please have a family member or caregiver assist you.

The information you provide will remain **confidential** and will in no way effect your health benefits or your enrollment in MVP. Please return the survey in the enclosed self-addressed, postage-paid envelope.

When we receive your completed survey, an MVP case manager will work closely with members who are identified as having specific health care needs. The case manager is a highly trained nurse clinician who is committed to working with our members to guide them through today's health care system. The case manager works closely with your primary care doctor to coordinate your care. Your primary doctor will always direct your medical treatment, while the case manager provides extra support to both you and your doctor.

If you have any questions about the survey, please call our Customer Care Center at 1-800-209-3945. TTY users should call 1-800-662-1220. Representatives are available to serve you Monday – Friday, 8 am – 8 pm, and Saturday, 8 am – 4 pm.

Sincerely,

A handwritten signature in black ink that reads "John M. Palmerini".

John M Palmerini  
Health Services Research

**Return the survey in the envelope provided to:**

Health Services Research • MVP Health Care • 220 Alexander Street • Rochester, NY 14607

«Member\_ID» «SURVEY»

Exhibit 4: Medicare Advantage Health Assessment Survey

1. In general, would you say your health is:
  - <sub>1</sub> Excellent
  - <sub>2</sub> Very Good
  - <sub>3</sub> Good
  - <sub>4</sub> Fair
  - <sub>5</sub> Poor
  
2. In the past 12 months, how many times have you stayed overnight as a patient in a hospital?
  - <sub>1</sub> Never
  - <sub>2</sub> 1 time
  - <sub>3</sub> 2 up to 3 times
  - <sub>4</sub> 3 or more times
  
3. In the past 12 months, how many times have you been seen in the emergency room?
  - <sub>1</sub> Never
  - <sub>2</sub> 1 time
  - <sub>3</sub> 2 times
  - <sub>4</sub> 3 or more times
  
4. In the past 12 months, how many times have you visited a physician or clinic?
  - <sub>1</sub> Never
  - <sub>2</sub> 1 time
  - <sub>3</sub> 2 to 3 times
  - <sub>4</sub> 4 to 6 times
  - <sub>5</sub> 7 or more times
  
5. How long have you been a patient of your primary care doctor?
  - <sub>1</sub> I am a new patient
  - <sub>2</sub> Less than 2 years
  - <sub>3</sub> Over 2 years
  
6. In the past 12 months, did you have diabetes?
  - <sub>1</sub> Yes
  - <sub>2</sub> No
  
7. Have you ever had coronary heart disease (hardening of the arteries)?
  - <sub>1</sub> Yes
  - <sub>2</sub> No
  - <sub>9</sub> Don't Know
  
8. Have you ever had pains associated with the heart and chest (angina pectoris)?
  - <sub>1</sub> Yes
  - <sub>2</sub> No
  - <sub>9</sub> Don't Know
  
9. Have you ever had a heart attack (myocardial infarction)?
  - <sub>1</sub> Yes
  - <sub>2</sub> No
  - <sub>9</sub> Don't Know
  
10. Have you ever had any other heart attack?
  - <sub>1</sub> Yes
  - <sub>2</sub> No
  - <sub>9</sub> Don't Know
  
11. Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?
  - <sub>1</sub> Yes
  - <sub>2</sub> No
  
12. Please check all those conditions for which you are **currently** receiving medical treatment.
  - <sub>1</sub> Breathing problems
  - <sub>2</sub> High blood pressure
  - <sub>3</sub> Heart problems
  - <sub>4</sub> Urinary problems (e.g. leaking urine)
  - <sub>5</sub> Arthritis
  - <sub>6</sub> Serious memory loss
  - <sub>7</sub> Ankle/leg swelling
  - <sub>8</sub> Cancer
  - <sub>9</sub> Dialysis

Exhibit 4: Medicare Advantage Health Assessment Survey

13. Do you live: (Check one answer)

- <sub>1</sub> Alone
- <sub>2</sub> Spouse (husband / wife)
- <sub>3</sub> Son or daughter
- <sub>4</sub> Other family: \_\_\_\_\_
- <sub>5</sub> Other non-family: \_\_\_\_\_

14. Do you have any adult children living **within a two hour drive**?

- <sub>1</sub> Yes
- <sub>2</sub> No → **GO TO QUESTION 16**

15. If you needed help, would you ask your children for assistance?

- <sub>1</sub> Yes
- <sub>2</sub> No

16. Where do you live? (Check one answer)

- <sub>1</sub> Your own home, apartment, condominium, or mobile home
- <sub>2</sub> An assisted-living apartment or board and care home
- <sub>3</sub> A nursing home
- <sub>9</sub> Other: \_\_\_\_\_

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

	(1) Able to do this without help	(2) Need some help	(3) Cannot do this at all without help	
Bathing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	A
Dressing	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	B
Eating	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	C
Toileting	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	D
Getting out of a chair	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	E
Getting out of bed	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	F
Walking	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	G
Climbing stairs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	H
Taking medications	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	I
Meal preparation	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	J
Housekeeping chores	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	K
Shopping and errands	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	L
Doing laundry	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	M
Transportation	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	N
Money management	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	O

18. Do you receive assistance from friends or family for any of the above tasks?

- <sub>1</sub> Yes
- <sub>2</sub> No

19. How many times have you fallen in the last few months?

- <sub>1</sub> Never
- <sub>2</sub> 1 time
- <sub>3</sub> 2 or more times

Exhibit 4: Medicare Advantage Health Assessment Survey

20. Are you currently receiving medical assistance or Medicaid?

- <sub>1</sub> Yes
- <sub>2</sub> No
- <sub>9</sub> Don't Know

21. In general, how many different prescription medicines do you take regularly? (Only count those your physician told you to take)

- <sub>1</sub> None
- <sub>2</sub> 1 to 2
- <sub>3</sub> 3 to 4
- <sub>4</sub> 5 or more

22. Do you receive any shots regularly (for example, insulin or B12)?

- <sub>1</sub> Yes
- <sub>2</sub> No

23. Do you use a catheter, oxygen supplies, or inhalers?

- <sub>1</sub> Yes
- <sub>2</sub> No

24. Are you currently participating in any clinical trials (e.g., special medical procedures or drugs under exploration with a physician)?

- <sub>1</sub> Yes
- <sub>2</sub> No

25. In the past 6 months, have you lost 10 pounds without trying?

- <sub>1</sub> Yes
- <sub>2</sub> No
- <sub>9</sub> Don't Know

26. How is your eyesight? (eyesight while wearing glasses or contacts, if you use them.)

- <sub>1</sub> Excellent
- <sub>2</sub> Good
- <sub>3</sub> Fair
- <sub>4</sub> Poor
- <sub>5</sub> Do not wear glasses or contacts

27. Are you currently receiving any home health care services from a nurse or personal care aide?

- <sub>1</sub> Yes
- <sub>2</sub> No

28. Do you often feel sad or blue?

- <sub>1</sub> Yes
- <sub>2</sub> No

29. Are you?

- <sub>1</sub> Male
- <sub>2</sub> Female

30. What is your date of birth?

Month		Day		Year	

31. Do you need or want an interpreter to communicate with a doctor or health care practitioner?

- <sub>1</sub> Yes
- <sub>2</sub> No

32. What language do you speak most of the time at home?

- <sub>1</sub> English
- <sub>2</sub> Spanish
- <sub>3</sub> Italian
- <sub>4</sub> German
- <sub>5</sub> Other: \_\_\_\_\_

33. This survey was completed by:

- <sub>1</sub> Self/Member
- <sub>2</sub> Spouse of member
- <sub>3</sub> Other family member
- <sub>9</sub> Other: \_\_\_\_\_



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