



Employer Handbook

For MVP Medicare Advantage Health plans

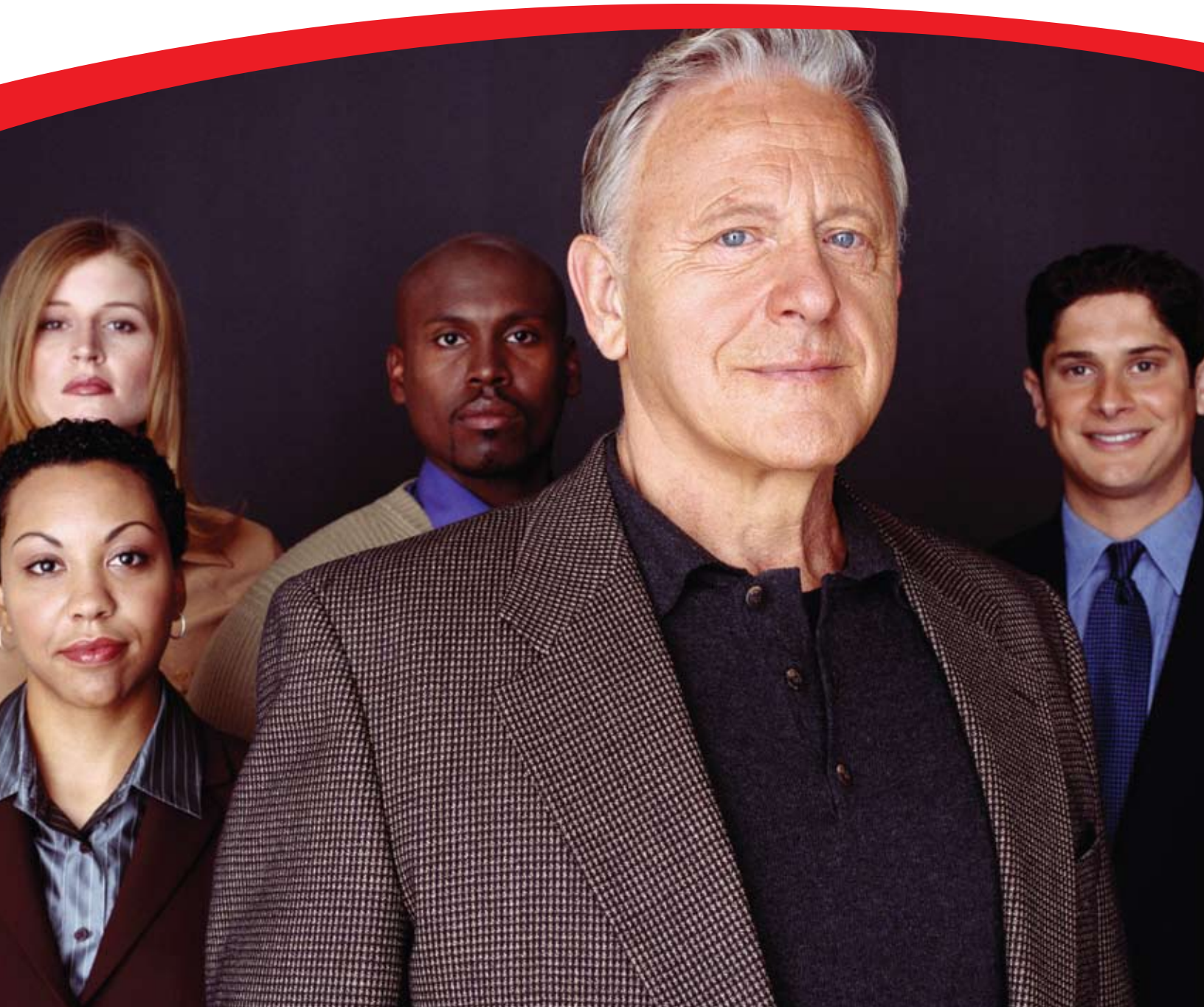


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For MVP Medicare Advantage Health Plans

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 Preferred Gold HMO and GoldAnywhere PPO
- 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 made periodically.

The A, B, C, and D of Medicare

Medicare eligibility

A person 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), but he or she may not join a Medicare HMO unless they were covered previously through a commercial plan with the same company, OR MVP has taken over the entire over age 65 retiree population 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 a person does 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 subject to an annual deductible and 80% coinsurance. Members pay the Part B premium monthly out of their Social Security check or pay a quarterly bill.

If Part B is declined when a person is 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.

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 differ for singles and married couples. Part B premiums may increase every year.

Medicare Part C for Medicare managed care plans (HMO, PPO)

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

In an HMO the primary care physician coordinates the member's health care. Usually a member needs a referral from the primary care physician to see a specialist. The benefits available under an HMO (Health Maintenance Organization) 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. Some services may require a prior authorization. A PPO gives the member the choice of receiving services within or outside of the participating provider network. The cost to the member will be more for services provided outside of the PPO's provider network.

Medicare Part D

Part D is the Medicare prescription drug benefit.

Part D provides access to prescription drug insurance coverage for individuals who are entitled to (eligible for and enrolled in) Medicare Part A or enrolled in Part B. Participation is voluntary and requires an affirmative election to join.

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.

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) 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.

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.

MVP Medicare Advantage plans offer plans with 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

The Centers for Medicare & Medicaid Services (CMS) pays MVP a monthly premium for each Medicare-eligible person enrolled in a Medicare Advantage plan. Premium payments vary by region. Any additional premium paid by an employer or individual covers the cost of additional services such as routine eye exams.

MVP is responsible for covering at least all the same services that would be covered by Original Medicare.

Eligibility requirements

A person is eligible to enroll in Preferred Gold HMO or GoldAnywhere PPO if they:

- Are enrolled in Medicare Part A and B by virtue of being age 65.
- 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.
- Do not have End Stage Renal Disease prior to enrolling, unless:
 - They are already enrolled as an MVP commercial health plan member.
 - Are diagnosed after the signature on the enrollment form before the enrollment effective date.
 - Are offered Preferred Gold HMO or GoldAnywhere PPO for the first time with the entire Employer Group Plan converting or consolidating to MVP.

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.

The enrollment process

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

Your retiree must complete a Preferred Gold HMO/ GoldAnywhere PPO 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 without 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.

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

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

Our Enrollment Department can accept a completed 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 employer authorization stamped enrollment form must be dated prior to the effective date.

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 a Preferred Gold HMO/GoldAnywhere PPO plan enrollment form up to 90 days prior to the effective date.

Q: How far back may a person retroactively enroll in a Preferred Gold/GoldAnywhere plan?

A: A person whose health coverage is sponsored by an employer group plan may be retroactively enrolled in a Preferred Gold 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 needs 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 a Preferred Gold/GoldAnywhere plan 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 Preferred Gold HMO/GoldAnywhere PPO?

A: A person must reside in the plan service area. There are two exceptions:

1. If a person is a member of an MVP under age 65 commercial benefit plan, and lives outside our plan service area (in an adjacent county), they are allowed to "roll over" into Preferred Gold HMO or GoldAnywhere PPO by virtue of age or disability. The member will be required to use in-plan providers for services if they are enrolled in Preferred Gold HMO.

2. If an employer is headquartered in the MVP service area and has retirees in an adjacent county to the service area. Retirees in this situation must use participating MVP plan providers, except for those enrolled in the GoldAnywhere PPO plan.

Q: How long may a Preferred Gold HMO/ GoldAnywhere PPO 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.

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. Verbal or written verification of the move by the member or the employer group will be accepted.

In some cases, CMS becomes aware of the member's permanent move out of the plan service area and automatically terms 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 Preferred Gold HMO/GoldAnywhere PPO enrollment packets.

Members turning 65 are sent a packet that explains the plan coverage appropriate to the member, based

on the Preferred Gold HMO or GoldAnywhere PPO plan offered through the employer. The information invites the person to enroll in a Preferred Gold plan. If the employer does not offer a Preferred Gold plan, the member is eligible to enroll in a Preferred Gold direct bill plan.

If in 30 days (60 days prior to the first of the month in which the person turns 65) the member has not responded, a second notice letter and enrollment packet is sent again.

If in another 30 days (30 days prior to the first of the month in which the person turns 65) the member still has not responded to the second notice, a telephone call is placed to the member.

If the member does not respond to any of these notifications, the employer will be contacted to make a determination as to 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. Preferred Gold HMO or GoldAnywhere PPO information is provided to the members on this list.

Completing the employer group enrollment form

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.

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, if married, their spouse as well, complete an employer group enrollment form. You need to review the information to make sure all sections are complete. After your review, the form should be sent to:

Preferred Gold HMO
Enrollment Department
220 Alexander St.
Rochester, NY 14607

When the 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.

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

1. Enter the employer group name and group number.
2. Select Preferred Gold HMO/GoldAnywhere PPO with prescription drug or without prescription drug.

Section 2: Member information

1. Enter the retiree’s last name, first name and middle initial.
2. Enter the retiree’s Social Security number.
3. Enter the retiree’s permanent home address and mailing address, if different.
4. 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.

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 are not required to select a PCP. Providers are listed in the MVP provider directory of health care professionals. Listings also are found at www.mvphealthcare.com.

1. Enter the PCP's full name. Note: Primary care physician selection is not required for a PPO plan.
2. Enter the provider's address, if the provider selected has more than one location.

Section 5: "Please read and answer the following questions"

Each of the questions in this section must be answered.

Section 6: Signature and authorization

1. The retiree provides their 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 needs to be attached.

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.

Member ID cards

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 use 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 Preferred Gold HMO/ GoldAnywhere PPO plan ID card, not their Medicare card, for medical services.

Medco ID cards

Retirees in Preferred Gold HMO/GoldAnywhere PPO 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 from the CMS approval of the retiree enrollment. Retirees must present their Medco card to obtain prescriptions at the pharmacy.

Disenrollment / termination

Voluntary disenrollment

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

The employer must notify the member of the disenrollment intent 21 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 the Preferred Gold direct bill plan.

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.

Notice requirements

The employer/union must provide prospective notice to the beneficiary that their plan enrollment is ending at least 21 days prior to the effective date of termination. This notice must include information about other individual plan options they may choose and how to request enrollment.

Notification to MVP

The employer/union will provide MVP with timely notice (30 days) of contract termination or the ineligibility of a member to participate in the sponsored plan. The employer/union will also provide MVP with copies of any notices sent to the beneficiary. In some cases, this supporting documentation may be needed to have the transaction processed at CMS.

Retroactive disenrollment

Disenrollments may be made retroactive under extremely limited circumstances. They must be justified in writing by the employer or member (or their 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.

We can accept a disenrollment form or a letter requesting disenrollment that is signed and dated. The letter should be sent to:

Preferred Gold HMO
Enrollment Department
220 Alexander St.
Rochester, NY 14607

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 a Preferred Gold 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 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.

OBRA

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 Secondary Payer

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.

Medicare Secondary Payer rules require an employer with 20 or more employees to make 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.

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, routine dental and routine physical 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.

Employers with 20 or more employees are subject to the Medicare Secondary Payer regulation.

Employers with less than 20 employees are not subject to the Medicare Secondary Payer regulation.

Laws that make Medicare the secondary payer

To preserve Medicare for future generations, Congress passed a series of laws 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.

Here is a summary of which plan is primary when an active member or dependent is eligible for Medicare:

Number of full time employees	Member status	Who is primary?	What law?
Under 20	Active employee or dependent	Medicare	Medicare Secondary Payer
Over 20	Active employee or dependent	Commercial plan	Medicare Secondary Payer
Under 100	Disabled active employee or dependent	Medicare	OBRA
Over 100	Disabled active employee or dependent	Commercial plan	OBRA

Premium invoice

Information on your invoice

Your premium invoice is based on your group's enrollment information at the time the invoice is produced. Preferred Gold HMO/GoldAnywhere PPO 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 Preferred Gold HMO/ GoldAnywhere PPO Part D plan. This could be retroactive based on the full dual eligibility effective date. If the employer does not have a prescription Part D plan, the retiree will be enrolled into the Preferred Gold/GoldAnywhere direct bill plan with Part D.

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 subsidy amount for Part D. 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 and moved to a separate division.

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 co-payments 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 as a separate division 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 account representative or Member Services 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 Member Services.

Member Services representatives are available Monday – Friday, from 7:00 a.m. to 8 p.m. Eastern Time. From November 15 – March 1, representatives also are available weekends from 8:00 a.m. to 8:00 p.m.

Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates counties contact:

(585) 327-2480 or (800) 665-7924

TTY: (585) 325-2629 or (800) 252-2452

All other New York State counties contact:

(800) 209-3945

TTY: (800) 662-1220

MVP Health Care Web site:

www.mvphealthcare.com

Medicare (CMS):

(800) MEDICARE

TTY: (877) 486-2048

Medicare Web site

www.medicare.gov



www.mvphealthcare.com