DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

[<Co_Logo>]

# Avoid a Late Enrollment Penalty (LEP)

If you don't respond to this notice by the date indicated on your letter, you will owe a Late Enrollment Penalty (LEP). You may be able to avoid this penalty by calling us or completing the attached "Declaration of Prior Prescription Drug Coverage" form.

## Why did I get this letter?

It appears you had a break in prescription drug coverage for 63 days or more. Because of that you may owe a Late Enrollment Penalty.

## What is a Late Enrollment Penalty (LEP)?

An LEP is a late fee Medicare charges if you had 63 days or more without prescription drug coverage. This can happen if:

- You didn't enroll in a Medicare Prescription Drug plan when you were first eligible.
- You didn't have a plan that met Medicare's minimum standards.

## How do I know if my old plan met Medicare's minimum standards?

Most plans that offer prescription drug coverage (like plans from employers or unions) must send their members a letter explaining how their coverage compares to Medicare Prescription Drug coverage. This letter tells you if the coverage you had was "creditable prescription drug coverage," which means that it met Medicare's minimum standards. If you didn't get a separate letter, your plan may have provided this information in its benefits handbook. If you don't know if the coverage you had met this standard, you should contact your old plan.

## What do I need to do?

If you believe you did not have a break in prescription drug coverage, we need more information about your old coverage so we can determine if it met Medicare's minimum standards (also known as "creditable coverage"). To give us this information, you can:

- Call us toll-free at the following:
  - MAPD: 1-800-643-4845, TTY 771, 8 a.m. – 8 p.m. local time, 7 days a week
  - PDP: 1-888-867-5575, TTY 771, 8 a.m. – 8 p.m. local time, 7 days a week

OR

- Complete the "Declaration of Prior Prescription Drug Coverage" form attached to this letter and mail it back to the following:

AARP Medicare
PO Box 30770
Salt Lake City, UT 84130-0770

## When do I need to respond?

You must respond by the date indicated on your letter to avoid the penalty.

## How much does the LEP cost?

The cost of the LEP depends on how long you went without creditable prescription drug coverage.

Medicare calculates the penalty by multiplying 1% of the "national base beneficiary premium" ($35.63 in 2017) by the number of full months you didn't have creditable coverage. The amount is rounded to the nearest $.10 and added to your monthly premium.

The national base beneficiary premium may increase each year, so your penalty amount may also increase each year.

## What if my coverage is through a group plan?

Contact your former employer, union group, or trust administrator. In some cases, they may pay the Late Enrollment Penalty for you.

## What if I have more questions?

If you have questions about LEP or the information in this letter call us at the following:

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- PDP: 1-888-867-5575, TTY 771, 8 a.m. – 8 p.m. local time, 7 days a week

You can also call Medicare at 1-800-633-4227, TTY 1-877-486-2048, 24 hours a day, 7 days a week. Or visit www.medicare.gov for online help.

[For MAPD Plans
Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

[For PDP Plans
Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。>

# Declaration of Prior Prescription Drug Coverage

Please use this form to tell us when you had creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards. Be sure to check every box that is true for you and complete the entire form.

UnitedHealthcare Member ID Number: _____

| Type of creditable coverage | When did you have this coverage? Start Date | End Date |
|---|---|---|
| ☐ Employer or union, or the Federal Employees Health Benefits Program | ___/___/___ | ___/___/___ |
| ☐ Medicaid, or a plan sponsored by my state, or a State Pharmaceutical Assistance Program called _____ in the state of _____ | ___/___/___ | ___/___/___ |
| ☐ The VA (Veterans Affairs) (veterans, survivor, or dependent benefits) | ___/___/___ | ___/___/___ |
| ☐ TRICARE or other military coverage | ___/___/___ | ___/___/___ |
| ☐ A Medigap (Medicare Supplemental) policy with creditable prescription drug coverage | ___/___/___ | ___/___/___ |
| ☐ The Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization | ___/___/___ | ___/___/___ |
| ☐ PACE (Program of All-Inclusive Care for the Elderly) | ___/___/___ | ___/___/___ |
| ☐ Other _____ | ___/___/___ | ___/___/___ |
| ☐ I had Extra Help from Medicare | ___/___/___ | ___/___/___ |

☐ I lived in an area affected by Hurricane Katrina in August, 2005. I joined a Medicare Prescription Drug plan before December 31, 2006. ___/___/___ ___/___/___

Name of Parish

_____

☐ I never had creditable prescription drug coverage

## By signing this form I am agreeing to the following:

The information I provided above is correct to the best of my knowledge. I may be asked to provide proof of my creditable coverage. If I didn't have creditable coverage or don't give proof of it, my monthly premium payment may be higher.

If someone signs for me, this person can only do so if my state law allows. This person must be able to show proof that he or she can legally sign for me.

UnitedHealthcare Member ID Number: _____

Signature _____ Date _____

Print Name _____

Member ID Number _____

## Member's Permanent Address:

Permanent Address _____ Apt. # _____

City _____ State _____ ZIP _____

If your permanent address is outside of the plan's service area, you will lose your plan coverage.

Date at Permanent Address _____

Primary Phone Number _____

Alternate Phone Number _____

E-mail Address (optional)* _____

*If you give an e-mail address, we'll send you plan updates from time to time. You can tell us at any time to stop sending these e-mails.

Medicare Health Insurance Claim Number _____

UnitedHealthcare Member ID Number: _____

If you are a representative of the member, you must also provide the following:

Signature _____ Date _____

Name _____

Street Address _____ Apt. # _____

City _____ State _____ ZIP _____

Phone Number _____

Relationship to Member _____

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We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

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