343PDPSGA1075001-05497-02

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

12-08-2014

[redacted]

Member ID: [redacted]

Dear [redacted]

Thank you for enrolling in UnitedHealthcare MedicareRx for Groups (PDP). Medicare has let us know that you may have to pay a Late Enrollment Penalty (LEP) as a part of your monthly premium payment.

Why do I have to pay an LEP?
Medicare has rules about prescription drug coverage. You need to pay an LEP if you did not have prescription drug coverage that met Medicare's minimum standards. This is called creditable coverage.

Medicare's records show that you did not have creditable coverage from 07/01/2014-12/31/2014.

What if I did have creditable coverage?
If you had creditable coverage during this time, you may not have to pay an LEP. Please contact us with more information about your old coverage:

- **By mail:** Fill out the form we sent with this letter and return it to: UnitedHealthcare MedicareRx for Groups (PDP), P.O. BOX 29350, Hot Springs, AR 71903-9350
- **By phone:** Call us to provide your plan information over the phone.

When is this information due?
Please return the form or call us by 01-07-2015. If we don't hear from you by this date, you may have to pay an LEP.

If you have any questions, please call Customer Service toll-free at **1-888-556-6648**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday - Friday.

If you have coverage through your former employer, union group or trust administrator (plan sponsor) they may pay the LEP for you. For questions about the LEP, please talk to your plan sponsor.

Sincerely,

[redacted]

The UnitedHealthcare Team

Enclosure

ATPDP2804E_0002
Y0066_PDP2804E_0002M Approved

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

Avoid a Late Enrollment Penalty (LEP)

If you don't respond to this notice by 01-07-2015, 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 am I getting this letter?
It appears that you had a break in prescription drug coverage for 63 days or more and you may owe a penalty.

What do I need to do?
We need more information about your old prescription drug coverage so we can determine if you had coverage that met Medicare's minimum standards. To give this information you can:

- Call us toll-free at **1-888-556-6648**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday - Friday, **OR**
- Complete the "Declaration of Prior Prescription Drug Coverage" form attached to this letter and mail it back to: UnitedHealthcare MedicareRx for Groups (PDP), P.O. BOX 29350, Hot Springs, AR 71903-9350

When do I need to respond?
You must respond by 01-07-2015 to avoid the penalty.

What is a late enrollment penalty (LEP)?
An LEP is a late fee Medicare charges if you had 63 days or more without coverage. This can happen if:

- You didn't enroll in a Medicare Prescription Drug plan when you were first eligible, **OR**
- 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 if I have questions?
If you have questions about LEP or the information in this letter call us at **1-888-556-6648**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday - Friday. 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.

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.

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UnitedHealthcare®

Declaration of Prior Prescription Drug Coverage

Check all of the boxes that are true for you. Please be sure to fill in the month and year for each box you check. **Note:** Complete both sides of the form. Any missing information may delay the processing of this form.

What type of coverage did you have?	Dates of Coverage (month and year)
☐ I had creditable* prescription drug coverage from an employer or union, including the Federal Employees Health Benefits Program (FEHBP).	From: ____/____ To: ____/____
☐ I had creditable* prescription drug coverage from Medicaid, a State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state. Name of SPAP: _____ If you are in a SPAP, what state do you live in: _____	From: ____/____ To: ____/____
☐ I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits).	From: ____/____ To: ____/____
☐ I had prescription drug coverage through my TRICARE or other military coverage.	From: ____/____ To: ____/____
☐ I had a Medigap (Medicare Supplemental) Policy with creditable* prescription drug coverage.	From: ____/____ To: ____/____
☐ I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U).	From: ____/____ To: ____/____
☐ I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly).	From: ____/____ To: ____/____
☐ I had creditable* prescription drug coverage from a source not listed above. Name of other source: _____	From: ____/____ To: ____/____
☐ I have or had Extra Help from Medicare to pay for my prescription drug coverage.	From: ____/____ To: ____/____
☐ I lived in an area affected by Hurricane Katrina in August 2005, and I joined a Medicare Prescription Drug plan before December 31, 2006. Name of Parish: _____	From: ____/____ To: ____/____
☐ I never had creditable* drug coverage	

* "Creditable" means that your earlier coverage met Medicare's minimum standards.

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Y0066_PDP2449E_0005M Approved

Please sign your name if you understand and agree to the following statement:

"I understand the information on this form is true and correct. I may be asked to prove that I had creditable prescription drug coverage. I understand that if I didn't have creditable coverage or don't give proof of it, my premium (monthly 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."

Sign your name: _____

Today's Date (month/day/year): _____

Member ID Number: _____

Member Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Medicare health insurance claim number: _____
UnitedHealthcare Member Number: 0162944911

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

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Relationship to Member: _____

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