



# 2025 Enrollment Guide

**UHC Dual Complete MS-V001 (HMO-POS D-SNP)**

H5008-016-000

**Service area:** Mississippi - Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Choctaw, Claiborne, Clarke, Clay, Coahoma, Copiah, Covington, DeSoto, Forrest, Franklin, George, Greene, Hancock, Harrison, Hinds, Holmes, Humphreys, Issaquena, Itawamba, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lafayette, Lauderdale, Lawrence, Leake, Lee, Leflore, Lincoln, Madison, Marion, Marshall, Monroe, Montgomery, Neshoba, Newton, Noxubee, Oktibbeha, Panola, Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Sharkey, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tishomingo, Tunica, Union, Walthall, Warren, Washington, Wayne, Webster, Wilkinson, Winston, Yalobusha, Yazoo counties

**United  
Healthcare®  
Dual Complete**

MS-V001 POS for dental only with form  
FBDE,QI,QMB,QMB+,SLMB,SLMB+

# UnitedHealthcare offers you Medicare coverage you can count on for your whole life ahead



## **Simplify your day with benefits built to be used**

Your UCard®, only from UnitedHealthcare, is more than just your member ID card. It gives you access to a large network of Medicare Advantage providers, including doctors and specialists. Plus, use it to help pay for OTC and healthy food, and shop for approved products from brands you know like Walmart, Walgreens and more with your earned rewards. Access your UCard and health information with the easy-to-use UnitedHealthcare app, rated #1 in health insurance. From choosing your plan, to using your plan, to enjoying your whole life ahead, UnitedHealthcare makes it easier than ever.



## **Get more for your Medicare dollar**

Get reliable care with low out-of-pocket costs. You've got big and small plans ahead of you, so feel confident managing your whole health with UnitedHealthcare Dual Complete coverage.



## **Expert guidance for today and as your needs change**

Count on us to be there when it matters. We'll help you find the right plan with easy-to-understand plan education, useful online tools and helpful UnitedHealthcare Medicare Plan Experts.<sup>1</sup> Our advocates and navigators help you get the answers and care you need. Put UnitedHealthcare's more than 45 years of experience to work for you.

<sup>1</sup>Medicare Plan Expert is a licensed insurance sales agent/producer.

# UCard opens doors where it matters

Once you're a member, you'll receive your new UnitedHealthcare UCard in the mail. Reach for your UCard when:



## Visiting a provider or filling a prescription

Your UCard has the plan information you and your providers need.



## Buying healthy food, OTC products or paying utility bills

Use the credit loaded on your UCard as payment in-store or online.



## Spending your earned rewards

Buy eligible items in-store at thousands of retailers nationwide.



## Checking in at the gym

Show your UCard to access your free membership the first time you visit a network gym or fitness location.



# Take advantage of a specially designed plan

This plan is for people with Medicare and Medicaid coverage and has many extra benefits that can help you live a healthier life. It has a network of quality doctors, hospitals, pharmacies and other providers, designed to help you get the care you need. And you have access to a large dental provider network. You can also get care from out-of-network dental providers but your costs may be higher, even for services with a \$0 copay.



## Here's how this HMO-POS D-SNP plan works



**Get care from providers in the network** or visit out-of-network providers for covered dental services.



**Select a primary care provider to oversee and help manage your care.** It's required by the plan, but it's also very beneficial for your long term health and well-being.



**\$0 copays for preventive services when received in-network.** Look at the Summary of Benefits in this book to find out what is covered and how much you'll pay for covered services.



**No referral is needed to see a network specialist or other provider.**



**This plan has a maximum annual out-of-pocket amount.** If you reach your limit, the plan will pay 100% of your Medicare-covered services for the rest of the plan year.



**Emergency and urgently needed services are covered anywhere in the world.**



**This plan includes prescription drug coverage.** Always use network pharmacies. You may pay more or the full cost for drugs received from pharmacies not in the network.

Go to **UHCCCommunityPlan.com** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions. See your Evidence of Coverage for a list of all covered services.

Scan this  
code to view  
the drug list



# Benefit Highlights

## UHC Dual Complete MS-V001 (HMO-POS D-SNP)

This is a short description of your 2025 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

| Plan costs                                                                                    |                                                                                          |                              |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------|
| Monthly plan premium                                                                          | \$0 with “Extra Help”                                                                    | \$47.30 without “Extra Help” |
|                                                                                               |                                                                                          |                              |
| Medical benefits                                                                              |                                                                                          |                              |
| Annual Medical Deductible                                                                     | No deductible                                                                            |                              |
| Annual out-of-pocket maximum (The most you may pay in a year for covered medical care)        | \$5,900                                                                                  |                              |
| Doctor’s office visit                                                                         |                                                                                          |                              |
| Primary care provider (PCP)                                                                   | \$0 copay                                                                                |                              |
| Specialist                                                                                    | \$25 copay (no referral needed)                                                          |                              |
| Virtual visits                                                                                | \$0 copay to talk with a network telehealth provider online through live audio and video |                              |
| Preventive services                                                                           | \$0 copay                                                                                |                              |
| Inpatient hospital care                                                                       | \$295 copay per day: days 1-7<br>\$0 copay per day: days 8 and beyond                    |                              |
| Skilled nursing facility (SNF)                                                                | \$0 copay per day: days 1-20<br>\$203 copay per day: days 21-100                         |                              |
| Outpatient hospital, including surgery (Cost sharing for additional plan services will apply) | \$295 copay                                                                              |                              |
| Outpatient mental health                                                                      |                                                                                          |                              |
| Group therapy                                                                                 | \$15 copay                                                                               |                              |
| Individual therapy                                                                            | \$25 copay                                                                               |                              |
| Virtual visits                                                                                | \$0 copay to talk with a network telehealth provider online through live audio and video |                              |

| Medical benefits                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Diabetes monitoring supplies                                   | \$0 copay for covered brands                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Diagnostic radiology services (such as MRIs, CT scans)         | \$205 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Diagnostic tests and procedures (non-radiological)             | \$20 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Lab services                                                   | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Outpatient x-rays                                              | \$15 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Ambulance                                                      | \$120 copay for ground or air                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Emergency care                                                 | \$90 copay (\$0 copay for emergency care outside the United States) per visit                                                                                                                                                                                                                                                                                                                                                                                                          |
| Urgently needed services                                       | \$30 copay (\$0 copay for urgently needed services outside the United States) per visit                                                                                                                                                                                                                                                                                                                                                                                                |
| Benefits and services beyond Original Medicare                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Routine physical                                               | \$0 copay, 1 per year                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Routine eye exams                                              | \$0 copay, 1 per year                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Routine eyewear                                                | <p>\$0 copay</p> <p>Plan pays up to \$300 every 2 years toward your purchase of 1 pair of frames (with a \$0 copay for standard lenses and a \$40 - \$153 copay for other covered lenses) or contact lenses (fitting and evaluation may be an additional cost) through network providers.</p> <p>Home delivered eyewear available through select network providers (select products only).</p> <p>You are responsible for all eyewear costs from providers outside of the network.</p> |
| Dental – preventive (covered in-network and out-of-network)    | \$0 copay for exams, cleanings, X-rays and fluoride*                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Dental – comprehensive (covered in-network and out-of-network) | <p>50% coinsurance on dentures and bridges</p> <p>\$0 copay for all other covered comprehensive services*</p>                                                                                                                                                                                                                                                                                                                                                                          |

| Benefits and services beyond Original Medicare       |                                                                                                                                                                                                                                                                         |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dental - benefit limit                               | \$1,250 combined limit on all covered dental services*                                                                                                                                                                                                                  |
| Hearing - routine exam                               | \$0 copay, 1 per year                                                                                                                                                                                                                                                   |
| Hearing aids                                         | <p>\$99 - \$829 copay for each OTC hearing aid. \$199 - \$1,249 copay for each prescription hearing aid. You can purchase up to 2 hearing aids every year through network providers.</p> <p>Includes hearing aids delivered directly to you (select products only).</p> |
| Fitness program                                      | \$0 copay, which includes a free gym membership, online fitness classes, and memory activities.                                                                                                                                                                         |
| Routine transportation                               | \$0 copay for 24 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies                                                                                                                                               |
| Foot care - routine                                  | \$25 copay, 6 visits per year                                                                                                                                                                                                                                           |
| Food, over-the-counter (OTC) and utility bill credit | \$94 credit every month to buy covered OTC products. Qualifying members can also use this credit to buy covered healthy food or pay certain utility bills.                                                                                                              |
| Rewards                                              | <p>Earn up to \$165 in rewards when you get started in January<sup>Ω</sup></p> <p>\$5 Meet your 2025 UCard, \$15 Annual Physical or Wellness Visit, \$10 each month Get Moving, \$10 Connect with others, \$10 Health Assessment, \$5 Flu Shot</p>                      |
| Meal benefit                                         | \$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay                                                                                                                                             |

\*Benefits are combined in and out-of-network

### Good news for 2025

The Coverage Gap, or "donut hole", has been eliminated and your out-of-pocket maximum cost is lower than ever. That means you're more protected from high drug costs in 2025.

| Prescription drugs |     |
|--------------------|-----|
| Deductible         | \$0 |

| Prescription drugs             |                                                                     |
|--------------------------------|---------------------------------------------------------------------|
| Initial Coverage               | 30-day or 100-day supply from retail or mail order network pharmacy |
| All covered drugs <sup>1</sup> | \$0 copay<br>(Some covered drugs are limited to a 30-day supply)    |

<sup>1</sup> You will pay a maximum of \$0 for each 1-month supply of Part D covered insulin drugs.



Eligibility for healthy food, utilities and \$0 copay for Rx benefits under the Value-Based Insurance Design model is limited to members with Extra Help from Medicare, and will be verified after enrollment.

<sup>2</sup> Medicare Advantage reward offerings may vary by plan and are not available in all plans. By participating in the program or accessing rewards funds, you agree to the Rewards Program Terms of Service located on the right side of the page at [myuhcmedicare.com/rewards](https://myuhcmedicare.com/rewards). Members must participate January through December to earn all available rewards. Rewards must be earned and reported within time frames specified by the plan. Time frames are available at [myuhcmedicare.com/rewards](https://myuhcmedicare.com/rewards). Rewards can only be used by members of UnitedHealthcare Medicare Advantage plans for eligible items at participating merchants and in accordance with applicable Medicare laws. Rewards funds are not redeemable for cash except as required by law. No ATM access. Rewards cannot be used to purchase Medicare-covered items or services, including medical or prescription drug out-of-pocket costs, or alcohol, tobacco or firearms. Rewards expire 1 month after Medicare Advantage plan terminates. This doesn't impact you while you're enrolled in your current plan or if you switch to another UnitedHealthcare Medicare Advantage plan. Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details. This information is not a complete description of benefits. Contact the plan for more information.





# Summary of Benefits 2025

**UHC Dual Complete MS-V001 (HMO-POS D-SNP)**  
H5008-016-000

Look inside to learn more about the plan and the health and drug services it covers.  
Contact us for more information about the plan.



**UHCCommunityPlan.com**



**Toll-free 1-844-560-4944, TTY 711**  
8 a.m.-8 p.m. local time, 7 days a week

**United  
Healthcare®**  
Dual Complete

Y0066\_SB\_H5008\_016\_000\_2025\_M

# Summary of Benefits

January 1, 2025 - December 31, 2025

This is a summary of what we cover and what you pay. For a complete list of covered services, limitations and exclusions, review the Evidence of Coverage (EOC) at [MyUHC.com/CommunityPlan](https://myuhc.com/CommunityPlan) or call Customer Service for help. After you enroll in the plan, you will get more information on how to view your plan details online.

## UHC Dual Complete MS-V001 (HMO-POS D-SNP)

| Medical premium, deductible and limits                                                   |                                                     |                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly plan premium                                                                     |                                                     | \$47.30                                                                                                                                                                                                                                                                                                                          |
| Part B premium reduction                                                                 |                                                     | \$1.60<br>If your Medicare Part B premium is paid by Medicaid, or others on your behalf, you will not see the reduction.                                                                                                                                                                                                         |
| Annual medical deductible                                                                |                                                     | This plan does not have a medical deductible.                                                                                                                                                                                                                                                                                    |
| Maximum out-of-pocket amount (does not include prescription drugs)                       |                                                     | \$5,900<br><br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers.<br><br>If you reach this amount, you will still need to pay your monthly premiums. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount. |
| Medical benefits                                                                         |                                                     |                                                                                                                                                                                                                                                                                                                                  |
| Inpatient hospital care <sup>2</sup>                                                     |                                                     | \$295 copay per day: days 1-7<br>\$0 copay per day: days 8 and beyond                                                                                                                                                                                                                                                            |
| Our plan covers an unlimited number of days for an inpatient hospital stay.              |                                                     |                                                                                                                                                                                                                                                                                                                                  |
| Outpatient hospital<br><br>Cost-sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC) <sup>2</sup>       | \$0 copay for a colonoscopy<br>\$245 copay otherwise                                                                                                                                                                                                                                                                             |
|                                                                                          | Outpatient hospital, including surgery <sup>2</sup> | \$0 copay for a colonoscopy<br>\$295 copay otherwise                                                                                                                                                                                                                                                                             |

## Medical benefits

|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
|                            | Outpatient hospital observation services <sup>2</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$295 copay                                                                              |
| <b>Doctor visits</b>       | Primary care provider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$0 copay                                                                                |
|                            | Specialists <sup>2</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | \$25 copay                                                                               |
|                            | Virtual medical visits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$0 copay to talk with a network telehealth provider online through live audio and video |
| <b>Preventive services</b> | Routine physical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$0 copay, 1 per year                                                                    |
|                            | Medicare-covered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$0 copay                                                                                |
|                            | <div> <div> <input type="checkbox"/> Abdominal aortic aneurysm screening <input type="checkbox"/> Alcohol misuse counseling <input type="checkbox"/> Annual wellness visit <input type="checkbox"/> Bone mass measurement <input type="checkbox"/> Breast cancer screening (mammogram) <input type="checkbox"/> Cardiovascular disease (behavioral therapy) <input type="checkbox"/> Cardiovascular screening <input type="checkbox"/> Cervical and vaginal cancer screening <input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) <input type="checkbox"/> Depression screening <input type="checkbox"/> Diabetes screenings and monitoring <input type="checkbox"/> Hepatitis C screening <input type="checkbox"/> HIV screening </div> <div> <input type="checkbox"/> Lung cancer with low dose computed tomography (LDCT) screening <input type="checkbox"/> Medical nutrition therapy services <input type="checkbox"/> Medicare Diabetes Prevention Program (MDPP) <input type="checkbox"/> Obesity screenings and counseling <input type="checkbox"/> Prostate cancer screenings (PSA) <input type="checkbox"/> Sexually transmitted infections screenings and counseling <input type="checkbox"/> Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) <input type="checkbox"/> Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19 <input type="checkbox"/> “Welcome to Medicare” preventive visit (one-time) </div> </div> |                                                                                          |

Any additional preventive services approved by Medicare during the contract year will be covered.

This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.

| Medical benefits                                                                                            |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Emergency care</b>                                                                                       |                                                                    | \$90 copay (\$0 copay for emergency care outside the United States) per visit. If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.                                                                                                                                                                                                                                                                                                                                                  |
| <b>Urgently needed services</b>                                                                             |                                                                    | \$30 copay (\$0 copay for urgently needed services outside the United States) per visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Diagnostic tests, lab and radiology services, and X-rays</b>                                             | Diagnostic radiology services (e.g. MRI, CT scan) <sup>2</sup>     | \$0 copay for each diagnostic mammogram<br>\$205 copay otherwise                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                             | Lab services <sup>2</sup>                                          | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                             | Diagnostic tests and procedures <sup>2</sup>                       | \$20 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                             | Therapeutic radiology <sup>2</sup>                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                             | Outpatient X-rays <sup>2</sup>                                     | \$15 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|  <b>Hearing services</b> | Exam to diagnose and treat hearing and balance issues <sup>2</sup> | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                             | Routine hearing exam                                               | \$0 copay, 1 per year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                             | Hearing aids <sup>2</sup>                                          | <p>\$99 - \$829 copay for each OTC hearing aid. \$199 - \$1,249 copay for each prescription hearing aid. You can purchase up to 2 hearing aids every year.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A broad selection of over-the-counter (OTC) and brand-name prescription hearing aids</li> <li><input type="checkbox"/> Access to one of the largest national networks of hearing professionals with more than 7,000 locations</li> <li><input type="checkbox"/> 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period</li> </ul> |

| Medical benefits                                                                                                                                               |                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>Routine dental benefits</b><br><br>Covered in-network and out-of-network. | Preventive and comprehensive <sup>2</sup>                                              | \$1,250 allowance for all covered dental services*<br><br>\$0 copay for covered preventive and comprehensive services like cleanings, fillings and crowns<br><br>50% coinsurance for bridges and dentures<br><input type="checkbox"/> No annual deductible<br><input type="checkbox"/> Access to one of the largest national dental networks<br><input type="checkbox"/> Freedom to see any dentist                                                                                                               |
|                                                                                                                                                                | Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup>             | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|  <b>Vision services</b>                                                       | Eyewear after cataract surgery                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                | Routine eye exam                                                                       | \$0 copay, 1 per year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                | Routine eyewear                                                                        | \$300 allowance for 1 pair of frames or contacts <ul style="list-style-type: none"> <li>• Free standard prescription lenses including single vision, bifocals, trifocals and Tier I (standard) progressives</li> <li>• Other covered lenses available with copays from \$40 – \$153</li> <li>• Access to one of Medicare Advantage’s largest national networks of vision providers and retail providers</li> <li>• Eyewear available from many online providers, including Warby Parker and GlassesUSA</li> </ul> |
|                                                                                                                                                                |                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Mental health</b>                                                                                                                                           | Inpatient visit <sup>2</sup><br>Our plan covers 90 days for an inpatient hospital stay | \$295 copay per day: days 1-7<br>\$0 copay per day: days 8-90                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                | Outpatient group therapy visit <sup>2</sup>                                            | \$15 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                | Outpatient individual therapy visit <sup>2</sup>                                       | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                | Virtual mental health visits                                                           | \$0 copay to talk with a network telehealth provider online through live audio and video                                                                                                                                                                                                                                                                                                                                                                                                                          |

| Medical benefits                                                                                                                                               |                                                                                                                            |                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b>Skilled nursing facility (SNF)<sup>2</sup></b><br>Our plan covers up to 100 days in a SNF.                                                                  |                                                                                                                            | \$0 copay per day: days 1-20<br>\$203 copay per day: days 21-100                                                          |
| <b>Outpatient rehabilitation services</b>                                                                                                                      | Physical therapy and speech and language therapy visit <sup>2</sup>                                                        | \$25 copay                                                                                                                |
|                                                                                                                                                                | Occupational Therapy Visit <sup>2</sup>                                                                                    | \$25 copay                                                                                                                |
|                                                                                                                                                                | Virtual medical visits                                                                                                     | \$0 copay to talk with a network telehealth provider online through live audio and video                                  |
| <b>Ambulance<sup>2</sup></b><br>Your provider must obtain prior authorization for non-emergency transportation.                                                |                                                                                                                            | \$120 copay for ground<br>\$120 copay for air                                                                             |
| <b>Routine transportation</b>                                                                                                                                  |                                                                                                                            | \$0 copay for 24 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies |
| <b>Medicare Part B prescription drugs</b><br>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Chemotherapy drugs <sup>2</sup>                                                                                            | 20% coinsurance                                                                                                           |
|                                                                                                                                                                | Part B covered insulin <sup>2</sup>                                                                                        | 20% coinsurance, up to \$35                                                                                               |
|                                                                                                                                                                | Other Part B drugs <sup>2</sup><br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | 20% coinsurance                                                                                                           |

### Good news for 2025

The Coverage Gap, or "donut hole", has been eliminated and your out-of-pocket maximum cost is lower than ever. That means you're more protected from high drug costs in 2025.

| Prescription drugs |     |
|--------------------|-----|
| <b>Deductible</b>  | \$0 |

| Prescription drugs             |                                                                        |  |
|--------------------------------|------------------------------------------------------------------------|--|
| Initial Coverage               | 30-day^ or 100-day supply from a retail or mail order network pharmacy |  |
| All covered drugs <sup>3</sup> | \$0 copay<br>(Some covered drugs are limited to a 30-day supply)       |  |

^Members living in long-term care facilities pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

<sup>3</sup> You will pay a maximum of \$0 for each 1-month supply of Part D covered insulin drugs.

| Additional benefits          |                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Chiropractic services</b> | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>2</sup> | \$20 copay                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Diabetes management</b>   | Diabetes monitoring supplies <sup>2</sup>                                                                 | <p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p> |
|                              | Diabetes self-management training                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                                    |
|                              | Therapeutic shoes or inserts <sup>2</sup>                                                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                              |
|                              | DME (e.g., wheelchairs, oxygen) <sup>2</sup>                                                              | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                              |
|                              | Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>                                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                              |

## Additional benefits

|                                                                                                          |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>Fitness program</b> |                                                  | <p>\$0 copay</p> <p>Your fitness program helps you stay active and connected at the gym, from home or in your community. It's available to you at no cost and includes:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Free gym membership</li> <li><input type="checkbox"/> Access to a large national network of gyms and fitness locations</li> <li><input type="checkbox"/> On-demand workout videos and live streaming fitness classes</li> <li><input type="checkbox"/> Online memory fitness activities</li> </ul> |
| <b>Foot care</b><br>(podiatry services)                                                                  | Foot exams and treatment <sup>2</sup>            | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                          | Routine foot care                                | \$25 copay, 6 visits per year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Meal benefit<sup>2</sup></b>                                                                          |                                                  | \$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Home health care<sup>2</sup></b>                                                                      |                                                  | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Hospice</b>                                                                                           |                                                  | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.                                                                                                                                                                                                                                                                                                                                           |
| <b>Opioid treatment program services<sup>2</sup></b>                                                     |                                                  | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Outpatient substance use disorder services</b>                                                        | Outpatient group therapy visit <sup>2</sup>      | \$15 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                          | Outpatient individual therapy visit <sup>2</sup> | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



| Additional benefits                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>Food, over-the-counter (OTC) and utility bill credit</b> | <p>\$94 credit every month to pay for OTC products, healthy food and utility bills</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Choose from thousands of OTC products, like first aid, pain relievers and more</li> <li><input type="checkbox"/> Buy healthy foods like fruits and vegetables, meat, seafood, dairy products and water</li> <li><input type="checkbox"/> Pay home utility bills like electricity, heat, water and internet</li> <li><input type="checkbox"/> Shop at thousands of participating stores, including Walmart, Walgreens, Dollar General and Kroger, or at neighborhood stores near you</li> </ul> |
| <b>Renal dialysis<sup>2</sup></b>                                                                                                             | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

<sup>2</sup> May require your provider to get prior authorization from the plan for in-network benefits.

\*Benefits are combined in and out-of-network

## Medicaid Benefits

Information for people with Medicare and Medicaid. Your services are paid first by Medicare and then by Medicaid.

The benefits described below are covered by Medicaid. You can see what State of Mississippi Division of Medicaid covers and what our plan covers.

**Coverage of the benefits depends on your level of Medicaid eligibility.** If Medicare doesn't cover a service or a benefit has run out, Medicaid may help, but you may have to pay a cost share. In some situations, Medicaid may pay your Medicare cost sharing amount. See your Medicaid Member Handbook for more details. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call State of Mississippi Division of Medicaid, 1-800-421-2408.

| Benefits                                                      | Medicaid    | UHC Dual Complete MS-V001 (HMO-POS D-SNP) |
|---------------------------------------------------------------|-------------|-------------------------------------------|
| <b>Inpatient Hospital Care</b>                                | Covered     | Covered                                   |
| <b>Doctor Office Visits</b>                                   | Covered     | Covered                                   |
| <b>Preventive Care</b>                                        | Covered     | Covered                                   |
| <b>Emergency Care</b>                                         | Covered     | Covered                                   |
| <b>Urgently Needed Services</b>                               | Covered     | Covered                                   |
| <b>Diagnostic Tests Lab and Radiology Services and X-Rays</b> | Covered     | Covered                                   |
| <b>Hearing Services</b>                                       | Covered     | Covered                                   |
| <b>Dental Services</b>                                        | Covered     | Covered                                   |
| <b>Vision Services</b>                                        | Covered     | Covered                                   |
| <b>Inpatient Mental Health Care</b>                           | Covered     | Covered                                   |
| <b>Mental Health Care</b>                                     | Covered     | Covered                                   |
| <b>Skilled Nursing Facility (SNF)</b>                         | Covered     | Covered                                   |
| <b>Ambulance</b>                                              | Covered     | Covered                                   |
| <b>Transportation (Routine)</b>                               | Not Covered | Covered                                   |
| <b>Prescription Drug Benefits</b>                             | Covered     | Covered                                   |
| <b>Chiropractic Care</b>                                      | Covered     | Covered with limitations                  |
| <b>Diabetes Supplies and Services</b>                         | Covered     | Covered                                   |
| <b>Durable Medical Equipment</b>                              | Covered     | Covered                                   |
| <b>Foot Care</b>                                              | Covered     | Covered                                   |
| <b>Home Health Care</b>                                       | Covered     | Covered                                   |
| <b>Hospice</b>                                                | Covered     | Covered                                   |

| Benefits                     | Medicaid | UHC Dual Complete<br>MS-V001 (HMO-POS D-<br>SNP) |
|------------------------------|----------|--------------------------------------------------|
| Outpatient Hospital Services | Covered  | Covered                                          |
| Renal Dialysis               | Covered  | Covered                                          |
| Prosthetic Devices           | Covered  | Covered                                          |

## About this plan

UHC Dual Complete MS-V001 (HMO-POS D-SNP) is a Medicare Advantage HMOPOS plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed below, and be a United States citizen or lawfully present in the United States.

You can enroll in this plan if you are in one of these Medicaid categories:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- **Qualifying Individual (QI):** Medicaid pays your part B premium only. The State Medicaid Office does not pay your cost-share. You do not have full Medicaid benefits. You pay the cost share amounts listed in the chart below. There may be some services that do not have a member cost share amount.
- **Specified Low-Income Medicare Beneficiary (SLMB+):** Medicaid pays your Part B premium and provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from your state Medicaid agency in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Medicaid pays your Part B premium only. The State Medicaid Office does not pay your cost-share. You do not have full Medicaid benefits. There may be some services that do not have a member cost share amount.
- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

If your category of Medicaid eligibility changes, your cost share may also increase or decrease. You must recertify your Medicaid enrollment to continue to receive your Medicare coverage.

Our service area includes these counties in:

**Mississippi:** Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Choctaw, Claiborne, Clarke, Clay, Coahoma, Copiah, Covington, DeSoto, Forrest, Franklin, George, Greene, Hancock, Harrison, Hinds, Holmes, Humphreys, Issaquena, Itawamba, Jackson, Jasper, Jefferson, Jefferson Davis, Jones, Kemper, Lafayette, Lauderdale, Lawrence, Leake, Lee, Leflore, Lincoln, Madison, Marion, Marshall, Monroe, Montgomery, Neshoba, Newton, Noxubee, Oktibbeha, Panola,

Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Sharkey, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tishomingo, Tunica, Union, Walthall, Warren, Washington, Wayne, Webster, Wilkinson, Winston, Yalobusha, Yazoo.

## **Use network providers and pharmacies**

UHC Dual Complete MS-V001 (HMO-POS D-SNP) has a network of doctors, hospitals, pharmacies and other providers. For routine dental services, you can use providers that are not in our network. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **UHCCommunityPlan.com** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

## Required Information

UHC Dual Complete MS-V001 (HMO-POS D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-866-263-1164 for additional information (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-866-263-1164, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 8 a.m. a 8 p.m.: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

Benefits, features, and/or devices vary by plan/area. Limitations, exclusions and/or network restrictions may apply.

### Hearing aids

Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider. Provider network size may vary by local market. OTC hearing aid warranties, if available, will vary by device and are handled through the manufacturer. One-time professional fee may apply for prescription hearing aids.

### Routine dental benefits

If your plan offers out-of-network dental coverage and you see an out-of-network dentist, you might be billed more. Provider network may vary in local market. Dental network size based on Zelis Network360, May 2023.

### Routine eyewear

Additional charges may apply for out-of-network items and services. Provider and retail network may vary in local market. Vision network size based on Zelis Network360, March 2023. Annual routine eye exam and \$100-450 allowance for contacts or designer frames, with standard (single, bi-focal, tri-focal or standard progressive) lenses covered in full either annually or every two years. Savings based on comparison to retail. Other vision providers are available in our network.

### Fitness program

Participation in the fitness program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. The fitness program includes standard fitness membership and other offerings. Fitness membership equipment, classes, activities and events may vary by location. Certain services, discounts, classes, activities, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

Gym network may vary in local market and plan.

AARP® Staying Sharp® is the registered trademark of AARP. Staying Sharp, including all content and features, is offered for informational purposes and to educate users on brain health care and medical issues that may affect their daily lives. Staying Sharp is based on a holistic, lifestyle approach to brain health that encourages users to incorporate into their daily lives activities that are associated with general wellness. Nothing in the service should be considered, or used as a substitute for, medical advice, diagnosis, or treatment. Features including the Cognitive Assessment and Lifestyle Check-Ins, Additional Tests, exercises, and challenges assess performance at a particular moment in time on certain discrete cognitive tasks. Staying Sharp games are intended for entertainment and recreational purposes only. Various factors may affect performance, including sleep, tiredness, focus, and other social, environmental, or emotional factors. Performance is not indicative of cognitive health and not predictive of future performance or medical conditions.

**Food, over-the-counter (OTC) and utility bill credit**

Food, OTC and utility benefits have expiration timeframes. Call your plan or review your Evidence of Coverage (EOC) for more information.

Eligibility for healthy food, utilities and \$0 copay for Rx benefits under the Value-Based Insurance Design model is limited to members with Extra Help from Medicare, and will be verified after enrollment.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

**Rewards Program**

Reward offerings may vary by plan and are not available in all plans. Reward program terms of service apply.

# Helpful resources

## You may qualify for Extra Help from Medicare

Extra Help is a program for people with limited incomes and resources who need help paying Part D premiums, deductibles and copays. To see if you qualify for Extra Help, call:

- The Social Security Administration at **1-800-772-1213**, TTY **1-800-325-0778** or visit **ssa.gov**
- Your state Medicaid office or visit **medicaid.gov**

## Resources for Caregivers

UnitedHealthcare offers resources and support for our members and the people who care for them. Ask about our caregiving resources the next time you call or visit **uhc.com/caregiving**.

## We're here to help

There's much more to good health than what happens in the doctor's office. Other factors — such as access to food, housing, transportation and financial stability — are just as important. We may be able to help connect you to discounts and services that make your life easier — all at no cost to you. These services may help you:



Save on utility bills, prescription drug expenses and even home repair costs



Find low-cost, easy-to-use transportation



Determine Medicaid eligibility, depending on your income



Find local support groups



Learn about Veterans' Services and support



For assistance, please call **1-866-427-1873**, TTY **711**, 8 a.m.–8 p.m. local time, Monday–Saturday to learn more about programs and eligibility.

## Medicare Made Clear®

Medicare Made Clear is an educational program from UnitedHealthcare designed to help you learn all you need to know about Medicare so you can make informed decisions about your health and Medicare coverage.



**MedicareMadeClear.com**



# Before you enroll

Make sure this plan is the right one for you. It's important that you understand how the plan works and what benefits are covered before you enroll in this plan. You can find plan documents at **UHCCommunityPlan.com**.



## **Did you check the online Drug List (Formulary) to make sure your prescription drugs are covered?**

Drugs not covered by the plan may have alternative drugs that can be used instead.



## **Did you check the online Provider Directory to make sure your providers are in the network?**

If your providers are not in the network, you will need to select a new network provider. You also have access to a large dental provider network. You can get care from out-of-network dental providers but your costs may be higher, even for services with a \$0 copay.



## **Did you review the online Pharmacy Directory to make sure the pharmacy you use is in the network?**

If your pharmacy is not in the network, you will need to select a new network pharmacy.



## **Did you look through the Summary of Benefits in this booklet to see how much you'll pay for medical services and prescription drugs?**

You can find a complete list of coverage, benefits and plan rules in the Evidence of Coverage online.



## **You're eligible to enroll in this Dual Special Needs Plan (D-SNP) if you:**



Are enrolled in Original Medicare Parts A and B



Receive state Medicaid benefits



Live in the plan's service area

# How to enroll

When you're ready to enroll, you have a few options to choose from. First, you'll need your Medicare card handy, no matter which option you choose.



## Online

Visit [UHCCommunityPlan.com](https://UHCCommunityPlan.com) or scan the code below to enroll online. Then follow these simple steps:

- 1 Enter your ZIP code
- 2 Look for the UHC Dual Complete MS-V001 (HMO-POS D-SNP) plan and select the Enroll button
- 3 Complete the form and submit your enrollment

If you need any help while enrolling online, select the Chat now button to connect with one of our Licensed Sales Representatives.



## By phone

Call one of our Licensed Sales Representatives toll-free at 1-844-560-4944, TTY 711, 8 a.m.-8 p.m. local time, 7 days a week to enroll over the phone or to schedule an appointment with an agent in your area.

If you already have an agent, they can review this plan with you to make sure it meets your needs before helping you enroll.



Enroll online or by phone for the easiest experience. Or, you can complete the enrollment request form and send it to us. If there isn't an enrollment form in this book, call the number above to request one.

Scan this code to  
complete your  
enrollment online



# What to expect after you enroll

Once you're a member, you'll find support for what matters, big and small. You can easily manage and find answers about your plan on the UnitedHealthcare app or your member site. And our UnitedHealthcare UCard® makes it easier than ever to unlock more from your Medicare Advantage plan.



**You are here**  
Enrollment  
submitted



Download the app  
or create your  
account online



UCard arrives in  
the mail – be sure  
to activate it



Coverage begins!  
Start using  
your plan

## Manage your plan online

If you haven't done so already, use your Medicare ID or member ID number and email address to create an account on the app or at **MyUHC.com/CommunityPlan**. Online you can:

- Find network providers and pharmacies and view plan documents, like your Drug List (Formulary)
- Complete your health assessment

## Once your coverage begins

- Schedule your annual physical and wellness visit
- Schedule your yearly in-home preventive care visit with UnitedHealthcare® HouseCalls. Visit **uhchousecalls.com** to learn more
- Get a 3-month supply of your prescriptions using a home delivery pharmacy service
- Review UnitedHealthcare UCard credit balances

## Thank you for choosing UnitedHealthcare

If you have questions, call the number on your UnitedHealthcare UCard.

Scan this code to  
download the  
UnitedHealthcare app



# Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Sales Agents use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary.

**Please check what you want to discuss with the Sales Agent (See the back of this page for definitions):**

- ☐ Medicare Advantage (Part C) plans and cost plans
- ☐ Dental, vision, hearing products
- ☐ Standalone Medicare prescription drug (Part D) plans
- ☐ Hospital indemnity products
- ☐ Medicare Supplement (Medigap) products

By signing this form, you agree to meet with a Sales Agent to discuss the products checked above. The Sales Agent is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They do not work directly for the federal government.

Signing this form does not affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

**Beneficiary or authorized representative signature and signature date:**

|                                                           |                       |
|-----------------------------------------------------------|-----------------------|
| <b>Signature of beneficiary/authorized representative</b> | <b>Today's date</b>   |
| <hr/>                                                     | <b>MM - DD - YYYY</b> |

If you are the authorized representative, please sign above and print clearly and legibly below:

|                       |                             |
|-----------------------|-----------------------------|
| Name (First and Last) | Relationship to beneficiary |
| <hr/>                 | <hr/>                       |

**To be completed by licensed sales representative** (please print clearly and legibly)

|                                   |                                                                  |                                              |
|-----------------------------------|------------------------------------------------------------------|----------------------------------------------|
| Sales Agent name (First and Last) | Sales Agent phone<br>[ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] | Sales Agent ID                               |
| Beneficiary name (First and Last) | Beneficiary phone<br>[ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] | Date of appointment<br><b>MM - DD - YYYY</b> |

Beneficiary address

|                           |                                                           |
|---------------------------|-----------------------------------------------------------|
| Initial method of contact | Plan(s) the Sales Agent will represent during the meeting |
| <hr/>                     | <hr/>                                                     |

Sales Agent signature

---

## Medicare Advantage plans (Part C) and cost plans

**Medicare Health Maintenance Organization (HMO) plan** — A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

**Medicare HMO point-of-service (HMO-POS) plan** — A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copay or coinsurance.

**Medicare preferred provider organization (PPO) plan** — A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.

**Medicare private fee-for-service (PFFS) plan** — A Medicare Advantage plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

**Medicare Special Needs Plan (SNP)** — A Medicare Advantage plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes and people who have certain chronic medical conditions.

**Medicare Medical Savings Account (MSA) plan** — MSA plans combine a high-deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

**Medicare cost plan** — In a Medicare cost plan, you can go to providers both in and out-of-network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

## Stand-alone Medicare prescription drug (Part D) plan

**Medicare prescription drug plan (PDP)** — A standalone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare private fee-for-service plans and Medicare Medical Savings Account Plans.

## Other related products

**Medicare Supplement (Medigap) Products** — Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare Part A and Part B, such as deductibles and coinsurance amounts for Medicare approved services.

**Dental, vision, hearing products** — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.

**Hospital indemnity products** — Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.



## 2025 Enrollment Request Form

☐ UHC Dual Complete MS-V001 (HMO-POS D-SNP) H5008-016-000

### Information about you (Please type or print in black or blue ink)

|                                     |            |                                                                   |
|-------------------------------------|------------|-------------------------------------------------------------------|
| Last name                           | First name | Middle initial                                                    |
| Birth date                          |            | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home phone number (       )       — |            | Mobile phone number (       )       —                             |

☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.

Social Security number

(Required for people who are enrolling in D-SNP plans): \_ \_ \_ - \_ \_ - \_ \_ \_ \_ \_

Medicare number

Permanent residence street address (**Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address**)

|      |        |       |          |
|------|--------|-------|----------|
| City | County | State | Zip code |
|------|--------|-------|----------|

Mailing address (**Only if it's different from above. You can give a P.O. box.**)

|      |       |          |
|------|-------|----------|
| City | State | Zip code |
|------|-------|----------|

Email address (optional)

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

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**Do you have other insurance that will cover your prescription drugs?**☐ Yes ☐ No

(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)

If **yes**, what is it?

Name of other insurance

|               |              |       |                  |
|---------------|--------------|-------|------------------|
| Member number | Group number | RxBin | RxPCN (optional) |
|---------------|--------------|-------|------------------|

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.****How do you want to pay?**

If you have a monthly plan premium (including any late enrollment penalty you may owe), you can pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. You can also pay from a bank account through Electronic Funds Transfer (EFT).

If you don't choose an option below, we'll send a bill each month to your mailing address.

If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA),

Social Security (SS) will send you a letter and ask you how you want to pay it:

- ☐ You can pay it from your SS check
- ☐ Medicare can bill you
- ☐ The Railroad Retirement Board (RRB) can bill you
- ☐ I want to pay from my Social Security check
- ☐ I want to pay from my Railroad Retirement Board (RRB) check
- ☐ I want to pay directly from a bank account

Account type ☐ Checking ☐ Savings

Account holder name: \_\_\_\_\_

Bank routing number \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Bank account number \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

**A few questions to help us manage your plan****1. Would you prefer plan information in another language or an accessible format?**

If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

Y0066\_ERFMA\_2025\_C

UHMS25HP0220732\_000

If you don't see the language or format you want, please call us toll-free at **1-844-560-4944**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHCCCommunityPlan.com** for online help.

**2. Are you enrolled in your state Medicaid program?**

☐ Yes ☐ No

If yes, please give us your Medicaid number: \_\_\_\_\_

**3. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.**

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, or Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin
- ☐ **I choose not to answer**

**4. What's your race? Select all that apply.**

☐ American Indian or Alaska Native ☐ Black or African American

Asian:

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian or Pacific Islander:

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ White
- ☐ **I choose not to answer**

☐ Member/Citizen of a federal or state recognized Tribe (name of Tribe) \_\_\_\_\_

**5. What is your gender? Select one.**

- ☐ Woman ☐ I use a different term: \_\_\_\_\_
- ☐ Man
- ☐ Non-binary ☐ **I choose not to answer**

**6. Which of the following best represents how you think of yourself? Select one.**

- ☐ Lesbian or gay ☐ I use a different term: \_\_\_\_\_
- ☐ Straight, that is, not gay or lesbian ☐ I don't know
- ☐ Bisexual ☐ **I choose not to answer**

**7. Do you or your spouse work?**

☐ Yes ☐ No

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Do you or your spouse have other health insurance that will cover medical services?  
(Examples: Other employer group coverage, LTD coverage, Workers' Compensation,  
auto liability, or Veterans benefits)

☐ Yes ☐ No

If yes, please complete the following:

Name of health insurance company

Member number

### 8. Please give us the name of your primary care provider (PCP), clinic or health center.

You can find a list on the plan website or in the Provider Directory.

Provider or PCP full name

Provider/PCP number

(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)

Are you now seeing or have you recently seen this provider? ☐ Yes ☐ No

### Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (For example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet or mobile phone.

### If you would rather have hard copies of required materials mailed to you, please check here:

- ☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

### Please read and sign

#### By completing this form, I agree to the following:

- ☐ I must keep both Hospital (Part A) and Medical (Part B) to stay in UnitedHealthcare. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- ☐ I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- ☐ I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document

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(also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.

- ☐ I understand that I can be enrolled in only one Medicare Advantage (MA) plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA Private Fee-for-Service (PFFS), MA Medicare Medical Savings Account (MSA) plans).
- ☐ **Release of information:** By joining this Medicare Advantage Plan, I acknowledge that the plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- ☐ I give UnitedHealthcare permission to share my protected health information with organizations or person(s) for permissible purposes under applicable law as required to administer my health plan.
- ☐ The information on this 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.
- ☐ My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**When I sign below, it means that I have read and understand the information on this form**

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare UCard®, I can call Customer Service at the number on my UnitedHealthcare UCard to update my authorization information on file.

**Signature of applicant/member/authorized representative**

**Today's date**

**If you are the authorized representative, please sign above and complete the information below** (\*Not a Sales Agent)

|                                |                           |          |
|--------------------------------|---------------------------|----------|
| Last name                      | First name                |          |
| Address                        |                           |          |
| City                           | State                     | Zip code |
| Phone number (       )       — | Relationship to applicant |          |

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

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**For individuals helping enrollee with completing this form only**

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

|           |                                                |
|-----------|------------------------------------------------|
| Name      | Relationship to enrollee                       |
| Signature | National Producer Number (Agents/Brokers only) |

**For Licensed Sales Representative/agency use only**

|                                          |                         |
|------------------------------------------|-------------------------|
| Licensed Sales representative/Writing ID | Initial receipt date    |
| Licensed Sales representative/agent name | Proposed effective date |
| Employer group name                      |                         |
| Employer group ID                        | Branch ID               |

**Agent must complete**

|                                                 |                                                          |                                                                     |                                                      |
|-------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> IEP (MA-PD enrollees)  | <input type="checkbox"/> ICEP (MA enrollees)             | <input type="checkbox"/> IEP (MA-PD enrollees eligible for 2nd IEP) | <input type="checkbox"/> OEP (Jan 1 - Mar 31)        |
| <input type="checkbox"/> OEP (Newly eligible)   | <input type="checkbox"/> SEP (Dual LIS change of status) | <input type="checkbox"/> SEP (Change in residence)                  | <input type="checkbox"/> SEP (Loss of EGHP coverage) |
| <input type="checkbox"/> SEP (Chronic)          | <input type="checkbox"/> SEP (Dual LIS maintaining)      | <input type="checkbox"/> AEP (October 15-December 7)                | <input type="checkbox"/> OEPI                        |
| <input type="checkbox"/> SEP (SEP reason) _____ |                                                          |                                                                     |                                                      |

Enrollee name \_\_\_\_\_

Agent name/ID number \_\_\_\_\_

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**Licensed Sales representative signature (optional)**
**Date**


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**Please mail or fax this completed form to:**

UnitedHealthcare  
P.O. Box 30769  
Salt Lake City , UT 84130-0769  
Fax: 1-888-950-1169  
Fax the front and back of each page

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**PRIVACY ACT STATEMENT:** The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) “Medicare Advantage Prescription Drug (MARx)”, System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

UHC Dual Complete MS-V001 (HMO-POS D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

OMB No. 0938-1378

Expires: 6/30/2026

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## Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

### Understanding the benefits

- ✓ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✓ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✓ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✓ Review the Formulary to make sure your drugs are covered.

### Understanding important rules

- ✓ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or another third party. This premium is normally taken out of your Social Security check each month.
- ✓ Benefits may change on January 1 of each year.
- ✓ Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care.
- ✓ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ✓ This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

# 2025 Enrollment receipt

To be completed if enrolling with a Licensed Sales Representative.

Please use this as your temporary proof of coverage until Medicare has confirmed your enrollment and you receive your UnitedHealthcare UCard®. This receipt is not a guarantee of enrollment.

This copy is for your records only. Please do not resubmit enrollment.

|                                            |                                            |
|--------------------------------------------|--------------------------------------------|
| <b>Applicant 1:</b>                        | <b>Applicant 2 (if applicable):</b>        |
| Name                                       | Name                                       |
| Application date - -                       | Application date - -                       |
| Proposed effective date - -                | Proposed effective date - -                |
| Plan name                                  | Plan name                                  |
| Plan type                                  | Plan type                                  |
| Health plan/PBP number                     | Health plan/PBP number                     |
| Enrollment tracking number (if applicable) | Enrollment tracking number (if applicable) |

**Call your Licensed Sales Representative if you have any questions:**

Representative name and ID number

Representative phone number

**RxBIN: 610097**

**Rx PCN: 9999**

**RxGRP: MPDCSP**

**We're here to help.** If you have additional questions, please call Customer Service toll-free at **1-844-560-4944**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week.

**Important reminder** - You don't need a Medigap or Medicare Supplement insurance plan with a Medicare Advantage plan. If you currently have a Medigap plan, contact the insurer to cancel your plan once your Medicare Advantage plan begins.



# Important information: 2024 Medicare star ratings



## UnitedHealthcare - H5008

For 2024, UnitedHealthcare - H5008 received the following Star Ratings from Medicare:

|                         |         |           |
|-------------------------|---------|-----------|
| Overall Star Rating:    | ★ ★ ★ ☆ | 3.5 stars |
| Health Services Rating: | ★ ★ ★ ☆ | 3.5 stars |
| Drug Services Rating:   | ★ ★ ★ ☆ | 3.5 stars |

Every year, Medicare evaluates plans based on a 5-star rating system.

### Why Star Ratings are Important

Medicare rates plans on their health and drug services. This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- ☐ Feedback from members about the plan’s service and care
- ☐ The number of members who left or stayed with the plan
- ☐ The number of complaints Medicare got about the plan
- ☐ Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

**The number of stars shows how well a plan performs.**

|           |               |
|-----------|---------------|
| ★ ★ ★ ★ ★ | EXCELLENT     |
| ★ ★ ★ ★   | ABOVE AVERAGE |
| ★ ★ ★     | AVERAGE       |
| ★ ★       | BELOW AVERAGE |
| ★         | POOR          |

### Get More Information on Star Ratings Online

Compare Star ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

### Questions about this plan?

Contact UnitedHealthcare 7 days a week from 8:00 a.m. to 8:00 p.m. Local time at **888-834-3721** (toll-free) or **711** (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time. Current members please call **866-263-1164** (toll-free) or **711** (TTY).

## Nondiscrimination notice

**Discrimination is against the law.** The company complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes.

If you believe you were treated unfairly because of your race, color, national origin, age, disability, or sex, you can send a grievance to our Civil Rights Coordinator.

- **Email:** **UHC\_Civil\_Rights@uhc.com**
- **Mail:** Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608, Salt Lake City, UT 84130

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- **Online:** **<https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>**
- **Phone:** Toll-free **1-800-368-1019, 800-537-7697** (TDD)
- **Mail:** U.S. Department of Health and Human Services  
200 Independence Ave SW, HHH Building, Room 509F  
Washington, D.C. 20201

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free phone number on your member identification card or listed on the cover of the booklet (TTY **711**), Monday through Friday, 8 a.m. to 8 p.m. ET.

This notice is available at

**<https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices>.**



## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, please call us using the toll-free number on your member identification card or listed on the cover of the booklet. Someone who speaks your language can help you. This is a free service.

**Spanish:** Contamos con servicios gratuitos de intérprete para responder cualquier pregunta que pudiera tener sobre nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al número de teléfono gratuito que figura en su tarjeta de identificación de miembro o en la portada del folleto. Una persona que habla su idioma podrá ayudarle. Es un servicio gratuito.

**Chinese Mandarin:** 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡或手冊封面列出的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

**Chinese Cantonese:** 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡或手冊封面列出的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo ng interpreter para sagutin anumang tanong na maaaring mayroon ka tungkol sa kalusugan o plano ng gamot. Para makakuha ng interpreter, pakitawagan kami gamit ang libreng numero na nasa iyong kard ng pagkakakilanlan ng kasapi o nakalista sa pabalat ng booklet. Sinumang nagsasalita ng wika mo ay puwedeng makatulong sa iyo. Ang serbisyo ng ito ay libre.

**French:** Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser sur notre régime d'assurance maladie ou d'assurance-médicaments. Pour recevoir l'aide d'un interprète, veuillez nous appeler en composant le numéro gratuit figurant sur votre carte d'identification de membre ou sur la première de couverture de la brochure. Quelqu'un parlant votre langue peut vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi mà bạn có về chương trình bảo hiểm sức khỏe hay thuốc của chúng tôi. Để gặp thông dịch viên, vui lòng gọi cho chúng tôi theo số điện thoại miễn phí trên thẻ nhận dạng hội viên của bạn hoặc ghi trên bìa của quyển sách nhỏ. Người nói cùng ngôn ngữ với bạn có thể giúp bạn. Đây là dịch vụ miễn phí.

**German:** Wir verfügen über kostenlose Dolmetscherdienste, um alle Fragen zu beantworten, die Sie über unseren Gesundheits- oder Medikamentenplan haben mögen. Um einen Dolmetscher zu erhalten, rufen Sie uns bitte unter der kostenfreien Nummer an, die auf Ihrem Mitgliedsausweis oder auf dem Umschlag der Broschüre aufgeführt ist. Jemand, der Ihre Sprache spricht, kann Ihnen helfen. Dies ist eine kostenlose Dienstleistung.

**Korean:** 건강 또는 의약품 플랜에 관한 질문에 답변해드리기 위해 무료 통역 서비스를 제공합니다. 통역 서비스를 이용하려면, 가입자 ID 카드 또는 이 소책자 표지에 나와 있는 수신자 부담 전화번호로 전화해 주십시오. 한국어를 사용하는 통역사가 도움을 드릴 수 있습니다. 이 서비스는 무료입니다.

**Russian:** Если у Вас возникнут какие-либо вопросы о нашем плане медицинского страхования или плане по приобретению препаратов, мы предоставим Вам бесплатные услуги устного перевода. Для того чтобы воспользоваться услугами устного перевода, пожалуйста, свяжитесь с нами по бесплатному номеру телефона, указанному на Вашей идентификационной карте участника плана или спереди на буклете. Сотрудник, который говорит на Вашем языке, сможет Вам помочь. Данная услуга предоставляется бесплатно.

**Arabic:** لدينا خدمات ترجمة فورية للرد على أي أسئلة قد تكون لديك حول الخطة الصحية أو خطة الأدوية الخاصة بنا. للحصول على مترجم، اتصل بنا باستخدام رقم الهاتف المجاني على بطاقة تعريف عضويتك أو على غلاف الكتيب. سيساعدك شخص ما يتحدث لغتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा प्लान के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं मौजूद हैं। दुभाषिया पाने के लिए, कृपया अपने सदस्य पहचान पत्र पर या पुस्तिका के अग्रभाग पर सूचीबद्ध टोल-फ्री नंबर का उपयोग करके हमें कॉल करें। आपकी भाषा बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

**Italian:** Mettiamo a disposizione un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per avvalersi di un interprete, si prega di chiamare il numero verde riportato sulla tessera identificativa o indicato sulla copertina dell'opuscolo. Una persona che parla italiano potrà fornire l'assistenza richiesta. Il servizio è gratuito.

**Portuguese:** Dispomos de serviços de intérprete gratuitos para esclarecer quaisquer dúvidas que tenha sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número gratuito no seu cartão de identificação de membro ou indicado na parte da frente do folheto. Alguém que fala a sua língua pode ajudá-lo(a). Este é um serviço gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou gendwa genyen konsènan plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, tanpri rele nou apati nimewo apèl gratis ki sou kat idantifikasyon manm ou an oswa ki endike sou kouvèti ti liv la. Yon moun ki pale lang ou ka ede ou. Sa se yon sèvis gratis.

**Polish:** Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszelkie pytania dotyczące naszego planu ubezpieczenia zdrowotnego lub planu refundacji leków. Aby skorzystać z pomocy tłumacza, proszę zadzwonić pod bezpłatny numer telefonu podany na Pana/Pani karcie identyfikacyjnej lub na okładce broszury. Osoba posługująca się Pana/Pani językiem Panu/Pani pomoże. Usługa ta jest bezpłatna.

**Japanese:** 当社の医療または処方薬プランに関する質問にお答えするために、無料の通訳サービスをご利用いただけます。通訳が必要な場合には、会員 ID カードまたは本冊子の表紙に記載されているフリーダイヤル番号を使用して、当社までお問い合わせください。お客様の言語を話す通訳者がお手伝いいたします。これは無料のサービスです。

## Notes and doodles

## Notes and doodles



## Notes and doodles

## Notes and doodles

## Notes and doodles



## Notes and doodles

## Notes and doodles

# Ready to use your extra benefits?

## UHC Dual Complete MS-V001 (HMO-POS D-SNP)

Take advantage of your additional plan benefits by using the providers below.



Call **1-866-263-1164**, TTY **711**, 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept or visit **MyUHC.com/CommunityPlan** for:

- ☐ Routine vision services: UnitedHealthcare Vision®
- ☐ Routine dental benefits: UnitedHealthcare Dental
- ☐ Fitness program: Renew Active®



### Hearing aids

UnitedHealthcare Hearing  
1-855-523-9355  
[UHChearing.com/Medicare](https://UHChearing.com/Medicare)



### Prescription drug home delivery

Optum® Home Delivery Pharmacy  
1-877-889-6358  
[MyUHC.com/CommunityPlan](https://MyUHC.com/CommunityPlan)



### Routine transportation

MTM  
1-844-525-3085  
[MyUHC.com/CommunityPlan](https://MyUHC.com/CommunityPlan)



### Food, over-the-counter (OTC) and utility bill credit

Solutran  
1-833-853-8587  
[MyUHC.com/CommunityPlan](https://MyUHC.com/CommunityPlan)



UnitedHealthcare has more than 45 years of experience serving members like you. You can count on us to be here when you need us. Call us when you need 1 on 1 support.

## We're happy to help



Download the UnitedHealthcare app



**UHCCommunityPlan.com**



Call toll-free **1-844-560-4944**, TTY **711**  
8 a.m.-8 p.m. local time, 7 days a week

Important plan information

Y0066\_EGCov\_2025\_C

Scan this code  
to download the  
**UnitedHealthcare**  
app



UHMS25PO0216190\_000