Annual Notice of Change 2026

UHC Dual Complete FL-D005 (Regional PPO D-SNP)

myUHC.com/CommunityPlan

Toll-free **1-866-842-4968,** TTY **711**
8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept

Do we have the right address for you?
If not, please let us know so we can keep you informed about your plan.

United Healthcare®

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Find updates to your plan for next year

This notice provides information about updates to your plan, but it doesn't include all of the details. Throughout this notice you will be directed to **myUHC.com/CommunityPlan** to review the details online. All of the below materials will be available online after **October 15, 2025.**

Provider Directory

Review the 2026 Provider Directory online to make sure your providers (primary care provider, specialists, hospitals, etc.) will be in the network next year.

Pharmacy Directory

Review the 2026 Pharmacy Directory online to see which pharmacies are in our network next year.

Drug List (Formulary)

You can look up which drugs will be covered by your plan next year and review any new restrictions on our website.

Evidence of Coverage (EOC)

Review your 2026 EOC for details about plan costs and benefits. The EOC is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. It also has information about the quality program, how medical coverage decisions are made and your Rights and Responsibilities as a member.

Reduce the clutter and get plan materials faster.

Visit **myUHC.com/CommunityPlan** to sign up for paperless delivery.

Would you rather get paper copies?

If you want a paper copy of what is listed above, contact our Customer Service at 1-866-842-4968 (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

UHC Dual Complete FL-D005 (Regional PPO D-SNP) offered by UnitedHealthcare

Annual Notice of Change for 2026

You're enrolled as a member of UHC Dual Complete FL-D005 (Regional PPO D-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 - December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in UHC Dual Complete FL-D005 (Regional PPO D-SNP).
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your Medicare & You 2026 handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the Evidence of Coverage. Get a copy at myUHC.com/CommunityPlan or call Customer Service at 1-866-842-4968 (TTY users call 711) to get a copy by mail.

More Resources

- 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 materials in other languages, braille, large print, audio, or you can ask for an interpreter. Call us toll-free at the number on your UnitedHealthcare UCard® or the front of your plan booklet.
- UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, materiales en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Llámenos al número gratuito que se encuentra en su UCard® de UnitedHealthcare o en la portada de la guía de su plan.

About UHC Dual Complete FL-D005 (Regional PPO D-SNP)

- Plans are 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.

- Our plan also has a written agreement with the Florida Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means UHC Dual Complete FL-D005 (Regional PPO D-SNP).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in UHC Dual Complete FL-D005 (Regional PPO D-SNP)**. Starting January 1, 2026, you'll get your medical and drug coverage through UHC Dual Complete FL-D005 (Regional PPO D-SNP). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of important costs for 2026

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 copayment for your deductible, doctor office visits, and inpatient hospital stays.

	2025 (this year)	2026 (next year)
Monthly plan premium* *Your premium can be higher or lower than this amount. (Go to Section 1.1 for details.)	$20.30	$4.80
Annual medical deductible	For 2025, your plan has a $257 combined in and out-of-network deductible. The deductible does not apply to insulin furnished through durable medical equipment (DME).	Your deductible is the Original Medicare Part B deductible amount, combined in and out-of-network. The 2025 Original Medicare deductible amount is $257. The 2026 amount will be set by CMS in the fall of 2025. Our plan will provide updated rates as soon as they are released. The deductible does not apply to insulin furnished through durable medical equipment (DME).
Maximum out-of-pocket amounts This is the **most** you'll pay out-of-pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $9,350 From in-network and out-of-network providers combined: $14,000	From network providers: $9,250 From in-network and out-of-network providers combined: $13,900

	2025 (this year)	2026 (next year)
	If you are eligible for Medicare cost-sharing assistance under Medicaid and your provider accepts Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	If you are eligible for Medicare cost-sharing assistance under Medicaid and your provider accepts Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	You pay a $0 copayment or 20% of the total cost per visit (in-network). You pay 40% coinsurance per visit (out-of-network).	You pay a $0 copayment or 20% of the total cost per visit (in-network). You pay 30% coinsurance per visit (out-of-network).
Specialist office visits	You pay a $0 copayment or 20% of the total cost per visit (in-network). You pay 40% of the total cost per visit (out-of-network).	You pay a $0 copayment or 20% of the total cost per visit (in-network). You pay 30% of the total cost per visit (out-of-network).
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	You pay a $0 copayment or a $1,365 copayment for each Medicare-covered hospital stay for unlimited days (in-network). You pay 40% of the total cost for each Medicare-covered hospital stay for	You pay a $0 copayment or a $1,860 copayment for each Medicare-covered hospital stay for unlimited days (in-network). You pay a $1,860 copayment for each Medicare-covered

	2025 (this year)	2026 (next year)
	unlimited days (out-of-network).	hospital stay for unlimited days (out-of-network).
Part D drug coverage deductible (Go to Section 1.7 for details.)	**If you do qualify for Extra Help from Medicare to help pay for your prescription drug costs**	
	$0	$0
	If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs	
	$590, except for covered insulin products and most adult Part D vaccines	$0 Tier 1 $615 Tier 2, Tier 3, Tier 4 and Tier 5, except for covered insulin and most adult Part D vaccines.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) **Important note:** Medicare has decided to end the Value Based Insurance Design (VBID) program on Dec. 31, 2025. This is an industry-wide change that impacts all Medicare Advantage insurance carriers. We were able to use this program to offer all covered Part D prescription drugs at $0 to members of your plan. In 2026, covered Tier 1 drugs will continue to be a $0 copayment. Due to the VBID program ending, what you pay for drugs on Tiers 2–5 is changing. Review this chart for your	**If you do qualify for Extra Help from Medicare to help pay for your prescription drug costs**	
	For all covered drugs: • $0 copayment[1]	If you are enrolled in Medicare A and B and receive Florida Medicaid Agency for Health Care Administration (AHCA) (Medicaid) benefits, depending on your income and institutional status, you pay one of the following amounts: For generic drugs (including brand drugs treated as generic): • $0 copayment or • $1.60 copayment or • $5.10 copayment

	2025 (this year)	2026 (next year)
cost-shares. For more details, review Section 1.7.		For all other covered drugs: • $0 copayment or • $4.90 copayment or • $12.65 copayment If the total amount you pay for copayments and coinsurance reaches $2,100, you pay nothing for your covered Part D drugs.
	If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs	
	You pay 25% of the total cost.[1]	Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage stage: Drug Tier 1: Standard retail cost-sharing (in-network) $0 per prescription. Drug Tier 2: Standard retail cost-sharing (in-network) 25% of the total cost. Drug Tier 3: Standard retail cost-sharing (in-network) 25% of the total cost. You pay 25%, up to $35 per month supply of each

	2025 (this year)	2026 (next year)
		covered insulin product on this tier[1] Drug Tier 4: Standard retail cost-sharing (in-network) 25% of the total cost. Drug Tier 5: Standard retail cost-sharing (in-network) 25% of the total cost.
	Catastrophic Coverage Stage: • During this payment stage, you pay nothing for your covered Part D drugs.	Catastrophic Coverage Stage: • During this payment stage, you pay nothing for your covered Part D drugs.

[1] In 2025, you pay no more than $0 for each 1-month supply of Part D covered insulin drugs. In 2026, you'll pay no more than a $35 copay or 25% of the total drug cost—whichever is less—until you reach the Catastrophic Coverage stage where your cost drops to $0. You pay these amounts even if you haven't paid your deductible.

Section 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	**$20.30**	**$4.80**
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B. If your Part B premium is lower than the reduction amount, you won't get the difference as a cash payment. The reduction only applies to what you owe for Part B unless it is paid for you by Medicaid.	**Up to $1.20** If your Medicare Part B premium is paid by Medicaid, or others on your behalf, you will not see the reduction.	**$0**

Section 1.2 Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Because our members also get help from Florida Medicaid Agency for Health Care Administration (AHCA) (Medicaid), very few members ever reach this out-of-pocket maximum.	$9,350 If you are eligible for Medicare cost-sharing assistance under Medicaid and your provider accepts Medicaid, you are not responsible for paying	$9,250 If you are eligible for Medicare cost-sharing assistance under Medicaid and your provider accepts Medicaid, you are not responsible for paying

	2025 (this year)	2026 (next year)
If you are eligible for Medicare cost-sharing assistance under Medicaid and your provider accepts Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Once you've paid $9,350 out-of-pocket for covered Part A and Part B services from network providers, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.	any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Once you've paid $9,250 out-of-pocket for covered Part A and Part B services from network providers, you'll pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Because our members also get help from Florida Medicaid Agency for Health Care Administration (AHCA) (Medicaid), very few members ever reach this out-of-pocket maximum. If you are eligible for Medicare cost-sharing help under Medicaid and your provider accepts Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Our plan premium and costs for prescription drugs don't	$14,000 If you are eligible for Medicare cost-sharing assistance under Medicaid and your provider accepts Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Once you've paid $14,000 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.	$13,900 If you are eligible for Medicare cost-sharing assistance under Medicaid and your provider accepts Medicaid , you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Once you've paid $13,900 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

	2025 (this year)	2026 (next year)
count toward your maximum out-of-pocket amount for medical services.		

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 Provider Directory (myUHC.com/CommunityPlan) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated Provider Directory:

- Visit our website at myUHC.com/CommunityPlan.
- Call Customer Service at 1-866-842-4968 (TTY users call 711) to get current provider information or to ask us to mail you a Provider Directory.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Service at 1-866-842-4968 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.2 of your Evidence of Coverage.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next year. Review the 2026 Pharmacy Directory (myUHC.com/CommunityPlan) to see which pharmacies are in our network. Here's how to get an updated Pharmacy Directory:

- Visit our website at myUHC.com/CommunityPlan.
- Call Customer Service at 1-866-842-4968 (TTY users call 711) to get current pharmacy information or to ask us to mail you a Pharmacy Directory.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-866-842-4968 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

Depending on your level of Medicaid eligibility, for Medicare-covered services:

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 copayment for your Medicare cost sharing.

If you are not a QMB or you do not have full Medicaid benefits, or you do have full Medicaid benefits and you see an out-of-network provider that does not accept Medicaid, you must pay your Medicare cost sharing.

Medicare cost sharing includes copayment, coinsurance, and deductibles. If you do not have Extra Help, you are responsible for all Part D cost sharing amounts. Please contact Florida Medicaid Agency for Health Care Administration (AHCA) (Medicaid) at 1-888-419-3456 for more details.

The healthy food benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as high blood pressure, high cholesterol, chronic and disabling mental health conditions, diabetes and/or cardiovascular disorders, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed. Contact us for details.

	2025 (this year)	2026 (next year)
Acupuncture for chronic low back pain (Medicare-covered)	You pay 40% of the total cost for services provided by a primary care physician (out-of-network). You pay 40% of the total cost for services provided by a specialist (out-of-network). Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor. See Chapter 4 of the Evidence of Coverage for details.	You pay 30% of the total cost for services provided by a primary care physician (out-of-network). You pay 30% of the total cost for services provided by a specialist (out-of-network). Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor. See Chapter 4 of the Evidence of Coverage for details.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Additional routine foot care	You pay a $0 copayment (in-network). You pay 40% of the total cost (out-of-network). We cover 8 in and out-of-network visits every year.	You pay a $0 copayment (in-network). You pay 30% of the total cost (out-of-network). We cover 8 in and out-of-network visits every year.
Annual medical deductible	For 2025, your plan has a $257 combined in and out-of-network deductible. The deductible does not apply to insulin furnished through durable medical equipment (DME).	Your deductible is the Original Medicare Part B deductible amount, combined in and out-of-network. The 2025 Original Medicare deductible amount is $257. The 2026 amount will be set by CMS in the fall of 2025. Our plan will provide updated rates as soon as they are released. The deductible does not apply to insulin furnished through durable medical equipment (DME).
Cardiac rehabilitation	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Cardiac rehabilitation - intensive	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Chiropractic services	You pay a $0 copayment (in-network).	You pay a $0 copayment or 20% of the total cost (in-network).
Chiropractic services	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Routine chiropractic services	Covered.	Not covered.
Chronic care management services, including chronic pain management and treatment plan services	This section did not exist in your 2025 Evidence of Coverage. If you have serious chronic conditions and receive chronic care management services, your provider develops a monthly comprehensive care plan that lists your health problems and goals, providers, medications, community services you have and need, and other information about your health. Your provider also helps coordinate your care when you go from one health care setting to another.	What you pay depends on who provides your chronic care management services. You will pay the cost-sharing that applies for services provided by your primary care provider, specialist, nurse practitioner, physician's assistant, or other non-physician health care professional. The in-network or out-of-network cost share rules will also apply. View the Evidence of Coverage for your specific cost-share amounts.
Diabetes self-management training, diabetic services and supplies	You pay a $0 copayment (in-network). We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch®Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide.	You pay a $0 copayment (in-network). We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan. Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
	Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView. Other brands are not covered by your plan. If you use a brand of supplies that is not covered by your plan, you should speak with your doctor to get a new prescription for a covered brand.	Chek Guide Me and Accu-Chek Guide. Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus. If you use a brand of supplies that is not covered by your plan, you should speak with your provider to get a new prescription for a covered brand.
Diabetes self-management training, diabetic services and supplies	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Diabetes self-management training, diabetic services and supplies - therapeutic shoes	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Durable medical equipment and related supplies	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Emergency care	You pay a $0 copayment or a $110 copayment.	You pay a $0 copayment or a $115 copayment.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Hearing services Routine hearing exam	You pay a $0 copayment (in-network). You pay 40% coinsurance (out-of-network). We cover 1 in or out-of-network exam every year.	You pay a $0 copayment (in-network). You pay 30% coinsurance (out-of-network). We cover 1 in or out-of-network exam every year.
Hearing services Medicare-covered hearing and balance exams	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Hearing services Hearing aids	You receive a $2,200 allowance for up to 2 OTC or prescription hearing aids every year. Home-delivered hearing aids are available nationwide through network providers (select products only). You must use network providers to access this benefit.	You receive a $1,500 allowance for up to 2 OTC or prescription hearing aids every 2 years. Home-delivered hearing aids are available nationwide through network providers (select products only). You must use network providers to access this benefit.
Inpatient hospital care	You pay a $0 copayment or $1,365 copayment for each Medicare-covered hospital stay for unlimited days (in-network).	You pay a $0 copayment or a $1,860 copayment for each Medicare-covered hospital stay for unlimited days (in-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Inpatient hospital care	You pay 40% of the total cost for each Medicare-covered hospital stay for unlimited days (out-of-network).	You pay a $1,860 copayment for each Medicare-covered hospital stay for unlimited days (out-of-network).
Inpatient mental health care	You pay a $0 copayment or a $1,365 copayment for each Medicare-covered hospital stay (in-network).	You pay a $0 copayment or a $1,860 copayment for each Medicare-covered hospital stay (in-network).
Inpatient mental health care	You pay 40% of the total cost for each Medicare-covered hospital stay (out-of-network).	You pay a $1,860 copayment for each Medicare-covered hospital stay (out-of-network).
Medicare Part B prescription drugs	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Medicare Part B prescription drugs - chemotherapy drugs	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Medicare Part B prescription drugs - covered insulin	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Outpatient diagnostic tests and therapeutic services and supplies – medical supplies	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Outpatient diagnostic tests and therapeutic services and supplies - radiation therapy	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Outpatient mental health care - group therapy session	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Outpatient mental health care - individual therapy session	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Outpatient rehabilitation services - occupational therapy	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Outpatient rehabilitation services - physical therapy and speech therapy	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Outpatient substance use disorder services - group therapy sessions	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Outpatient substance use disorder services - individual therapy sessions	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
OTC, home and bath safety devices, fitness, in-home support services, caregiver support, and weight management credit **Healthy food and utilities - Special Supplemental Benefits for the Chronically Ill**	$50 credit a month loaded to your UnitedHealthcare UCard® for covered OTC products, healthy food, certain utility bills and home and bath safety devices. Use your UCard online or in-store to access your benefits. Your credit amount expires at the end of each month. The healthy food and utility bills options are only available to qualifying members through the Value Based Insurance Design (VBID) program. Fitness equipment, wearables, and extra support with in-home services, respite care and weight management are not covered by the credit. Important note: Medicare has decided to end the VBID program on Dec. 31, 2025. This is an industry-wide change that impacts all Medicare Advantage insurance carriers. The VBID program let Medicare Advantage	$49 credit a month loaded to your UnitedHealthcare UCard® for covered OTC products, home and bath safety devices, select fitness equipment and wearables, and extra support with in-home services, respite care and weight management. If you qualify, you can also use it to pay for healthy food and certain utility bills. The healthy food and utility bills options are provided through the Special Supplemental Benefits for the Chronically Ill (SSBCI). These options are only available to chronically ill enrollees with a qualifying condition, such as chronic high blood pressure, chronic high cholesterol, chronic and disabling mental health conditions, diabetes and/or cardiovascular disorders, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed. If you use an out-of-network provider for in-

	2025 (this year)	2026 (next year)
	insurance carriers provide members with tailored benefits, like grocery assistance or lowered costs for prescriptions. We were able to use this program to offer a healthy food and utility bills credit to members of your plan.	home services, respite care or weight management coaching, you pay 75% of the total cost. Use your UCard online or in-store to access your benefits. Your credit amount expires at the end of each month. Visit member.uhc.com/community/benefits/ssbci after Oct. 1, 2025 or view your Evidence of Coverage for more information. Important note: Due to the VBID program ending, we will use the SSBCI program to continue to offer benefits like healthy food and utilities. Because of this change, you will need to have a qualifying chronic condition to use your OTC credit to help pay for healthy food and utilities.
Partial hospitalization and intensive outpatient services	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Physician/practitioner services, including doctor's office visits - Medicare-covered hearing and balance exams	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Physician/practitioner services, including doctor's office visits - primary care provider	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Physician/practitioner services, including doctor's office visits - specialists	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Podiatry services (Medicare-covered)	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Prosthetic devices and related supplies	You pay 40% of the total cost (out-of-network).	You pay 20% of the total cost (out-of-network).
Pulmonary rehabilitation	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Skilled nursing facility (SNF) care	You pay a $0 copayment each day for days 1-100, or: You pay the Original Medicare cost sharing amount for skilled nursing services. $0 copayment each day for days 1 to 20 (in-network). $209.50 copayment each day for days 21 to 100 (in-network).	You pay a $0 copayment each day for days 1-100, or: You pay the Original Medicare cost sharing amount for 2026 which will be set by CMS in the fall of 2025. These are 2025 cost sharing amounts and may change for 2026. Our plan will provide updated rates as soon as they are released. $0 copayment each day for days 1 to 20 (in-network). $209.50 copayment each day for days 21 to 100 (in-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Skilled nursing facility (SNF) care	You pay 40% of the total cost for each skilled nursing facility stay (out-of-network).	You pay the Original Medicare cost sharing amount for 2026 which will be set by CMS in the fall of 2025. These are 2025 cost sharing amounts and may change for 2026. Our plan will provide updated rates as soon as they are released. $0 copayment each day for days 1 to 20 (out-of-network). $209.50 copayment each day for days 21 to 100 (out-of-network).
Supervised exercise therapy (SET)	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Transportation (additional routine)	Covered	Not covered
Urgently needed services	You pay a $0 copayment or a $45 copayment for each visit.	You pay a $0 copayment or a $40 copayment for each visit.
Vision care Medicare-covered eye exams to evaluate for eye disease	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).
Vision care Medicare-covered eyewear	You pay a $0 copayment (out-of-network).	You pay 40% of the total cost (out-of-network).
Vision care Medicare-covered visits	You pay 40% of the total cost (out-of-network).	You pay 30% of the total cost (out-of-network).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

	2025 (this year)	2026 (next year)
Vision care Additional routine eye exams	You pay a $0 copayment (in-network). You pay 40% coinsurance (out-of-network). We cover 1 in or out-of-network exam every year.	You pay a $0 copayment (in-network). You pay 30% coinsurance (out-of-network). We cover 1 in or out-of-network exam every year.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits, then your deductible, coinsurance, and/or copayment may be less for services that are covered under Original Medicare. Please refer to the **Changes to Benefits and Costs for Medical Services** chart.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. **You can get the complete Drug List** by calling Customer Service at 1-866-842-4968 (TTY users call 711) or visiting our website (**myUHC.com/CommunityPlan**). This material will be available online after **October 15, 2025**.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your Evidence of Coverage and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. Call Customer Service at 1-866-842-4968 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs, which tells you about

your drug costs. If you get Extra Help, you will receive a LIS Rider. If you don't get this material, call Customer Service at 1-866-842-4968 (TTY users call 711) and ask for the LIS Rider to be sent to you.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 2, Tier 3, Tier 4 and Tier 5 drugs until you reach the yearly deductible.

- **Stage 2: Initial Coverage**

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date out-of-pocket costs reach $2,100.

- **Stage 3: Catastrophic Coverage**

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	$0 (Look at the separate insert, the LIS Rider, for your deductible amount.) If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs: $590	$0 (Look at the separate insert, the LIS Rider, for your deductible amount.) If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs: $615

	2025 (this year)	2026 (next year)
		During this stage, you pay $0 for drugs on Tier 1 (in-network standard retail 30-day supply), and the full cost of drugs on Tier 2, Tier 3, Tier 4 and Tier 5 until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

If you do not receive Extra Help in 2026, your cost share for covered drugs on Tier 2, Tier 3, Tier 4 and Tier 5 in the Initial Coverage Stage is changing from a copayment to coinsurance. Go to the following table for the changes from 2025 to 2026.

Coinsurance is a portion or part of the total cost, typically as a percentage. With this plan, you pay part of the cost of Tier 2, Tier 3, Tier 4 and Tier 5 drugs. For example, if your coinsurance is 25% and the total cost of your prescription is $100, you would pay $25. The plan pays the rest. You pay the full cost of your drugs until you meet the deductible, then you'll start paying the coinsurance amount.

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your **Evidence of Coverage**.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
	If you do qualify for Extra Help from Medicare to help pay for your prescription drug costs	
Generic drugs (including brand drugs treated as generic)	$0 copayment	If you are enrolled in Medicare A and B and receive Florida Medicaid Agency for Health Care Administration (AHCA) (Medicaid) benefits,

	2025 (this year)	2026 (next year)
		depending on your income and institutional status, you pay one of the following amounts: • $0 copayment or • $1.60 copayment or • $5.10 copayment
For all other covered drugs	$0 copayment	If you are enrolled in Medicare A and B and receive Florida Medicaid Agency for Health Care Administration (AHCA) (Medicaid) benefits, depending on your income and institutional status, you pay one of the following amounts: • $0 copayment or • $4.90 copayment or • $12.65 copayment
	If you do not qualify for Extra Help from Medicare to help pay for your prescription drug costs	
Tier 1 - Preferred Generic	You pay 25% of the total cost.[1]	You pay $0 per prescription.
Tier 2 - Generic		You pay 25% of the total cost.
Tier 3 - Preferred Brand		You pay 25% of the total cost. You pay 25%, up to $35 per month supply of each covered insulin product on this tier[1].

	2025 (this year)	2026 (next year)
Tier 4 - Non-Preferred Drug		You pay 25% of the total cost.
Tier 5 - Specialty Tier		You pay 25% of the total cost.

[1] In 2025, you pay no more than $0 for each 1-month supply of Part D covered insulin drugs. In 2026, you'll pay no more than a $35 copay or 25% of the total drug cost—whichever is less—until you reach the Catastrophic Coverage stage where your cost drops to $0. You pay these amounts even if you haven't paid your deductible.

Changes to your VBID Part D Benefit

Medicare has decided to end the Value Based Insurance Design (VBID) program on Dec. 31, 2025. This is an industry-wide change that impacts all Medicare Advantage insurance carriers. The VBID program let Medicare Advantage insurance carriers provide members with tailored benefits, like grocery assistance or lowered costs for prescriptions. We were able to use this program to offer all covered Part D prescription drugs at $0 to members of your plan.

In 2026, covered Tier 1 drugs will continue to be a $0 copayment. Due to the VBID program ending, what you pay for drugs on Tiers 2–5 is changing. The amount you pay is determined by Medicare and depends on what drug stage you're in, the level of Extra Help you receive and whether it's a brand or generic drug. If you reach the Catastrophic Coverage stage, you will have a $0 copayment on all covered drugs for the rest of the plan year. For more details on your cost-shares, review the Part D tables above.

Changes to the Catastrophic Coverage Stage

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6, in your **Evidence of Coverage**.

Section 2 Administrative Changes

	2025 (this year)	2026 (next year)
Emergency care - Worldwide reimbursement	Foreign emergencies and urgently needed services are covered while you are travelling. Payment requests from intermediaries, claims management companies or third-party billers for services received outside of the United States are not reimbursable.	Foreign emergencies and urgently needed services are covered while you are travelling. Payment requests from intermediaries, claims management companies or third-party billers for services received outside of the United States are not reimbursable. The EOC now includes some additional instructions on how to get foreign services directly reimbursed to you or the provider. Please see Chapter 7 Section 1 of the EOC for complete information.
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1-866-842-4968 (TTY users call 711) or visit Medicare.gov.
Transplant services - Travel & lodging	If you receive an in-network transplant at a location outside your local community pattern of care, some travel and lodging expenses related to your transplant may be covered.	The EOC has been updated to include more details explaining allowable transplant-related travel and lodging expenses. Please see Chapter 4, Section 3 of the EOC for more details.

Section 3 How to Change Plans

To stay in our plan, you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our UHC Dual Complete FL-D005 (Regional PPO D-SNP).

If you want to change plans for 2026 follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from UHC Dual Complete FL-D005 (Regional PPO D-SNP).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from UHC Dual Complete FL-D005 (Regional PPO D-SNP).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll or visit our website to disenroll online (myUHC.com/CommunityPlan). Call Customer Service at 1-866-842-4968 (TTY users call 711) for more information on how to do this. Or call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty.
- **To learn more about Original Medicare and the different types of Medicare plans,** visit Medicare.gov, check the **Medicare & You 2026 handbook,** call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE. As a reminder, UnitedHealthcare Insurance Company or one of its affiliates offers other Medicare health plans AND/OR Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people can have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare with a separate Medicare prescription drug plan,
- Original Medicare without a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

Section 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week;
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP in your state. For information on eligibility criteria, covered drugs, how to enroll in the program, or if you're currently enrolled, how to continue getting help, call the ADAP in your state. You can find your state's ADAP contact information in Chapter 2 of the **Evidence of Coverage.** Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option.

This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.

- Extra Help from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 1-866-842-4968 (TTY users call 711) or visit Medicare.gov.

Section 5 Questions?

Get Help from UHC Dual Complete FL-D005 (Regional PPO D-SNP)

- **Call Customer Service at 1-866-842-4968. (TTY users call 711).**

  We're available for phone calls 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. Calls to these numbers are free.

- **Read your 2026 Evidence of Coverage**

  This **Annual Notice of Change** gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 **Evidence of Coverage** for UHC Dual Complete FL-D005 (Regional PPO D-SNP). The **Evidence of Coverage** is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the **Evidence of Coverage** on our website at **myUHC.com/CommunityPlan** or call Customer Service at 1-866-842-4968 (TTY users call 711) to ask us to mail you a copy.

- **Visit myUHC.com/CommunityPlan**

  Our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (formulary/drug list). The Provider Directory and Formulary will be available after **October 15, 2025**.

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Florida, the SHIP is called Florida Serving Health Insurance Needs of Elders (SHINE).

Call Florida Serving Health Insurance Needs of Elders (SHINE) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Florida Serving Health Insurance Needs of Elders (SHINE) at 1-800-963-5337**.**

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

  You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with Medicare.gov**

You can chat live at Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044.

- **Visit Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read Medicare & You 2026**

  The Medicare & You 2026 handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Get Help from Medicaid

Call Florida Medicaid Agency for Health Care Administration (AHCA) (Medicaid) at 1-888-419-3456. TTY users can call 1-800-955-8771 for help with Medicaid enrollment or benefit questions.

Notice of availability
of language assistance services and alternate formats

ATTENTION: Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

ملاحظة: إذا كنت تتحدث **اللغة العربية** (Arabic)، ستتوفر لك خدمات المساعدة اللغوية المجانية ه والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على ى بطاقة تعريف العضو خاصتك.

請注意：如果您說**中文 (Chinese)**，**您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。**

ATTENTION : Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfugung. Rufen Sie die gebuhrenfreie Nummer auf Ihrer Mitgliedskarte an.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો વિના મૂલ્યે ભાષાકીય મદદરૂપ સેવાઓ અને અન્ય ફોર્મેટમાં વિના મૂલ્યે સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. તમારા સભ્ય ઓળખ કાર્ડ પરના ટોલ-ફ્રી નંબર પર કૉલ કરો.

ATANSYON: Si w pale **Kreyol Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lot foma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ATTENZIONE: se parla **italiano (Italian)**, puo usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

알림 사항: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicaçoes gratuitas em outros formatos, como caracteres grandes. Ligue para o numero gratuito que se encontra no seu cartão de identificação de membro.

ВНИМАНИЕ! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

ATENCIÓN: Si habla **espanol (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposicion. Llame al numero gratuito que figura en su tarjeta de identificacion de miembro.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

โปรดทราบ หากคุณ**พูดภาษาไทย** (Thai) ได้ คุณสามารถใช้บริการช่วยเหลือด้านภาษาฟรีและการสื่อสารในรูปแบบอื่น ๆ ฟรี เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทรไปยังหมายเลขโทรฟรีสำหรับสมาชิกตามบัตรประจำตัวของคุณ

ЗВЕРНІТЬ УВАГУ! Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як от набрані великим шрифтом. Телефонуйте на безкоштовний номер телефону, зазначений на вашій ідентифікаційній картці учасника.

LƯU Ý: Nếu quý vị noi **Tiếng Việt** (Vietnamese), quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngon ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí co trên thẻ định danh thành viên của quý vị.

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Our Companies comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member identification card (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

UHC_Civil_Rights@uhc.com

Optum Civil Rights Coordinator
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If you need help filing a complaint, call the toll-free number on your member identification card (TTY **711**).

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

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**

Phone: **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at: **https://www.uhc.com/nondiscrimination-med**
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Call **1-866-842-4968**

Calls to this number are free. 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free.
8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

Write: **P.O. Box 30769**
Salt Lake City, UT 84130-0769

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