# 2026 Enrollment Guide

**UHC Dual Complete OH-D001 (HMO D-SNP)**

H5253-059-000

**Service area:** Ohio - Butler, Clark, Cuyahoga, Franklin, Greene, Hamilton, Madison, Mahoning, Montgomery, Stark, Summit, Trumbull, Warren counties

United Healthcare®
Dual Complete

OH-D001
FBDE, QI, QMB, QMB+, SLMB, SLMB+

# Whatever comes next, UnitedHealthcare provides Medicare coverage you can count on for your whole life ahead

You've got plans. So do we. Medicare plans from UnitedHealthcare offer reliable coverage designed to support your health wherever life takes you. Our large national provider network includes doctors and specialists across the country, and 9 out of 10 Medicare members are able to keep seeing the doctors they know and trust. It's one more way we're here to support your health — every step of the way.

After all, you may not always know what's next, but you can count on UnitedHealthcare to be there from the moment you choose your plan to the moments that matter most.

## See why 4 out of 5 members would choose UnitedHealthcare again for their Medicare coverage

"I really appreciated all of the help that I got from UnitedHealthcare. UnitedHealthcare is the company that is best suited to my needs."

**— Karen K, UnitedHealthcare Medicare Advantage Member**

"You need a strong insurance company behind you to back you up and cover the things that need to be covered and UnitedHealthcare does that."

**— Mary M, UnitedHealthcare Complete Care Member**

Medicare member responses based on Human8 survey, May 2025.

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# 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.

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

**Always use network providers.** The plan does not cover medical care received from providers outside the network. (Except for emergency care, urgent care and renal dialysis 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**.

**Some services require a referral from your doctor.** Check your Summary of Benefits for details.

**This plan has a maximum annual out-of-pocket amount**.

**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.

**This plan includes Special Supplemental Benefits for the Chronically Ill (SSBCI),** allowing eligible members—whose condition is verified by their provider—to use plan credits for healthy food and utilities, along with OTC and other wellness support products.

Go to **UHC.com/CommunityPlan** 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**

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# Benefit Highlights

## UHC Dual Complete OH-D001 (HMO D-SNP)

This is a short description of your 2026 plan benefits. The values shown represent a range based upon the amount of the Medicare Parts A and B cost sharing covered by the state. For complete information and for costs for those without Medicare Parts A and B cost sharing covered by the state, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

**Plan costs**

**If you have full Medicaid benefits or are a Qualified Medicare Beneficiary, you will pay $0 for your Medicare-covered services.** You may have small copays for your Part D prescription drugs. If your eligibility for Medicaid or "Extra Help" changes, your cost sharing and premium may change.

| | With Medicaid Cost Share Assistance | Without Medicaid Cost Share Assistance |
|---|---|---|
| **Monthly plan premium** | $0 with "Extra Help" | $28.30 without "Extra Help" |
| **Annual medical deductible** (applies to certain medical benefits) | $0 | $283 |
| **Annual out-of-pocket maximum** (the most you may pay in a year for covered medical care) | $0 | $9,250 |

| Plan benefits | | |
|---|---|---|
| Your plan has a deductible that applies to certain medical benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. | | |
| | **With Medicaid Cost Share Assistance** | **Without Medicaid Cost Share Assistance** |
| **Doctor's office visit** | | |
| Primary care provider (PCP) | $0 copay | 20% coinsurance |
| Specialist | $0 copay (referral needed) | 20% coinsurance (referral needed) |
| Virtual visits | $0 copay to talk with a network telehealth provider online through live audio and video | $0 copay to talk with a network telehealth provider online through live audio and video |
| **Preventive services** | $0 copay | $0 copay |
| **Inpatient hospital care** | $0 copay per stay for unlimited days | $2,230 copay per stay for unlimited days |
| **Skilled nursing facility** (SNF)(Stay must meet Medicare coverage criteria) | $0 copay per day: days 1-100 | $0 copay per day: for days 1-20<br>$217 copay per day: days 21-100 |
| **Outpatient hospital, including surgery** (cost sharing for additional plan services will apply) | $0 copay | 20% coinsurance |
| **Outpatient mental health** | | |
| Group therapy | $0 copay | 20% coinsurance |
| Individual therapy | $0 copay | 20% coinsurance |
| Virtual visits | $0 copay to talk with a network telehealth provider online through live audio and video | $0 copay to talk with a network telehealth provider online through live audio and video |

| Plan benefits | | |
|---|---|---|
| | **With Medicaid Cost Share Assistance** | **Without Medicaid Cost Share Assistance** |
| **Durable medical equipment (DME) and related supplies** | | |
| DME (e.g., wheelchairs, oxygen) | $0 copay | 20% coinsurance |
| Prosthetics (e.g., braces, artificial limbs) | $0 copay | 20% coinsurance |
| **Diabetes monitoring supplies** | $0 copay for covered brands | $0 copay for covered brands |
| **Diagnostic radiology services** (such as MRIs, CT scans) | $0 copay | 20% coinsurance |
| **Diagnostic tests and procedures** (non-radiological) | $0 copay | 20% coinsurance |
| **Lab services** | $0 copay | $0 copay |
| **Outpatient x-rays** | $0 copay | 20% coinsurance |
| **Ambulance** | $0 copay for ground or air | 20% coinsurance for ground or air |
| **Emergency care** | $0 copay (worldwide) | $115 copay ($0 copay for emergency care outside the United States) per visit |
| **Urgently needed services** | $0 copay (worldwide) | $40 copay ($0 copay for urgently needed services outside the United States) per visit |

| Additional plan benefits | |
|---|---|
| **Routine physical** | $0 copay, 1 per year |

| Additional plan benefits | | |
|---|---|---|
| **Hearing services** | Routine hearing exam | $0 copay for a routine hearing exam to help support hearing health |
| | Hearing aids | $0 copay for 2 hearing aids every 2 years<br>• A broad selection of over-the-counter (OTC), high-value and brand-name prescription hearing aids<br>• Access to one of the largest national networks of hearing professionals with more than 6,500 locations<br>• 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period<br>• Hearing aids purchased outside of UnitedHealthcare Hearing are not covered |
| **Routine dental benefits** | Preventive and comprehensive services | $0 copay for covered preventive and comprehensive services like cleanings, fillings, crowns and dentures<br>• No annual deductible<br>• Access to one of the largest national dental networks |
| **Vision services** | Routine eye exam | $0 copay, 1 per year |
| | Routine eyewear | $0 copay for 1 pair standard lenses/frames and $150 allowance toward your purchase of contact lenses every year |
| **Fitness program** | | $0 copay<br>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:<br>• Free gym membership at core and premium locations<br>• Access to a large national network of gyms and fitness locations<br>• On-demand workout videos and live streaming fitness classes<br>• Online memory fitness activities |
| **Routine transportation** | | $0 copay for 36 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies |
| **Foot care - routine** | | $0 copay, 8 visits per year |

| Additional plan benefits | |
|---|---|
| **OTC, healthy food, utilities + wellness support** | $133 credit every month for over-the-counter (OTC) products and wellness support, plus healthy food and utilities for qualifying members<br>•Choose from thousands of OTC products, like first aid supplies, pain relievers and more<br>•Buy healthy foods like fruits, vegetables, meat, seafood, dairy products and water<br>•Shop at thousands of participating stores, including Walmart, Walgreens and Dollar General, or at neighborhood stores near you<br>•Pay home utilities like electricity, heat, water and internet<br>•Get wellness support including in-home services, weight management coaching, respite care, select fitness items and more |
| **Rewards** | Earn up to $180 in rewards when you get started in January[Ω] |
| **Meal benefit** | $0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay |

| Prescription drugs | |
|---|---|
| If you don't qualify for Low-Income Subsidy (LIS), you pay the Medicare Part D cost share outlined in the Evidence of Coverage. If you do qualify for Low-Income Subsidy (LIS) you pay: | |
| **Deductible** | Your deductible amount is $0 |
| **Initial Coverage** | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,100 you move to the Catastrophic Coverage stage. |
| **Drug coverage** | **30-day or 100-day supply from retail network pharmacy** |
| **Generic (including brand drugs treated as generic)** | $0, $1.60, or $5.10 copay<br>Drugs that are in Tier 1* are always $0 copay.<br>(Some covered drugs are limited to a 30-day supply) |
| **All other drugs[1]** | $0, $4.90, or $12.65 copay<br>Drugs that are in Tier 1* are always $0 copay.<br>(Some covered drugs are limited to a 30-day supply) |

| Prescription drugs | |
|---|---|
| **Catastrophic Coverage** | Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. |

[1] You pay no more than 25% of the total drug cost or a $35 copay, whichever is lower, for each 1-month supply of Part D covered insulin drugs, even if you haven't paid your deductible, until you reach the Catastrophic Coverage stage where you pay $0.
*Tier 1 includes enhanced drug coverage.

**Scan this code to view your Summary of Benefits**

United Healthcare® Dual Complete

The healthy food and utilities benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as diabetes, cardiovascular disorders, chronic heart failure, chronic high blood pressure and/or chronic high cholesterol, and who also meet all applicable plan coverage criteria. There may be other qualified chronic conditions not listed.
[Ω]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. 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. 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.

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# Summary of Benefits 2026

**UHC Dual Complete OH-D001 (HMO D-SNP)**
H5253-059-000

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

**UHC.com/CommunityPlan**

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

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Y0066_SB_H5253_059_000_2026_M

# Summary of Benefits

## January 1, 2026 - December 31, 2026

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** 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 OH-D001 (HMO D-SNP)

| Medical premium, deductible and limits | |
|---|---|
| **Monthly plan premium** | $28.30 |
| **Part B premium reduction** | Up to $0.60<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** | Your medical deductible is $283 as described in the Plan Deductible chart later in this document. Until you have paid the deductible amount, you must pay the full cost of your covered medical services. |
| **Maximum out-of-pocket amount** (does not include prescription drugs) | $9,250<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. |
| **Medicare cost-sharing** | If you have full Medicaid benefits or are a Qualified Medicare Beneficiary (QMB), you will pay $0 for your Medicare-covered services as noted by the cost-sharing in this chart. |

| Medical benefits | |
|---|---|
| **Inpatient hospital care**[2]<br>Our plan covers an unlimited number of days for an inpatient hospital stay. | $0 copay per stay, or<br>$2,230 copay per stay |

| Medical benefits | | |
|---|---|---|
| **Outpatient hospital**<br>Cost-sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC)[2] | $0 copay for a colonoscopy<br>$0 copay or 20% coinsurance otherwise |
| | Outpatient hospital, including surgery[2] | $0 copay for a colonoscopy<br>$0 copay or 20% coinsurance otherwise |
| | Outpatient hospital observation services[2] | $0 copay or 20% coinsurance |
| **Doctor visits** | Primary care provider | $0 copay or 20% coinsurance |
| | Specialists[1,2] | $0 copay or 20% coinsurance |
| | Virtual medical visits | $0 copay to talk with a network telehealth provider online through live audio and video |
| **Preventive services** | Routine physical | $0 copay, 1 per year |
| | Medicare-covered | $0 copay<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screening<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings and monitoring<br>• Hepatitis C screening<br>• HIV screening<br>• Lung cancer with low dose computed tomography (LDCT) screening<br>• Medical nutrition therapy services<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screenings and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screenings and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19 |

| Medical benefits | | |
|---|---|---|
| | | • "Welcome to Medicare" preventive visit (one-time)<br><br>Any additional preventive services approved by Medicare during the contract year will be covered.<br>This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers. |
| **Emergency care** | | $0 copay or $115 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. |
| **Urgently needed services** | | $0 copay or $40 copay ($0 copay for urgently needed services outside the United States) per visit |
| **Diagnostic tests, lab and radiology services, and X-rays** | Diagnostic radiology services (e.g. MRI, CT scan)[2] | $0 copay for each diagnostic mammogram<br>$0 copay or 20% coinsurance otherwise |
| | Lab services[2] | $0 copay |
| | Diagnostic tests and procedures[2] | $0 copay or 20% coinsurance |
| | Therapeutic radiology[2] | $0 copay or 20% coinsurance |
| | Outpatient X-rays[2] | $0 copay or 20% coinsurance |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues[2] | $0 copay or 20% coinsurance |
| | Routine hearing exam | $0 copay for a routine hearing exam to help support hearing health |
| | Hearing aids[2] | $0 copay for 2 hearing aids every 2 years<br><br>• A broad selection of over-the-counter (OTC), high-value and brand-name prescription hearing aids<br>• Access to one of the largest national networks of hearing professionals with more than 6,500 locations |

| Medical benefits | | |
|---|---|---|
| | | • 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period<br>• Hearing aids purchased outside of UnitedHealthcare Hearing are not covered |
| **Routine dental benefits** | Preventive and comprehensive services[2] | $0 copay for covered preventive and comprehensive services like cleanings, fillings, crowns and dentures<br>• No annual deductible<br>• Access to one of the largest national dental networks |
| **Vision services** | Exam to diagnose and treat diseases and conditions of the eye[2] | $0 copay |
| | Eyewear after cataract surgery | $0 copay |
| | Routine eye exam | $0 copay, 1 per year |
| | Routine eyewear | $0 copay for 1 pair standard lenses/frames and $150 allowance toward your purchase of contact lenses every year |
| **Mental health** | Inpatient visit[2]<br>Our plan covers 90 days for an inpatient hospital stay | $0 copay per stay, or<br>$2,080 copay per stay |
| | Outpatient group therapy visit[2] | $0 copay or 20% coinsurance |
| | Outpatient individual therapy visit[2] | $0 copay or 20% coinsurance |
| | Virtual mental health visits | $0 copay to talk with a network telehealth provider online through live audio and video |
| **Skilled nursing facility (SNF)[2]**<br>(Stay must meet Medicare coverage criteria)<br>Our plan covers up to 100 days in a SNF. | | $0 copay per day: days 1-100, or<br>$0 copay per day: days 1-20<br>$217 copay per day: days 21-100 |

| Medical benefits | | |
|---|---|---|
| **Outpatient rehabilitation services** | Physical therapy and speech and language therapy visit[1,2] | $0 copay or 20% coinsurance |
| | Occupational Therapy Visit[1,2] | $0 copay or 20% coinsurance |
| **Ambulance[2]**<br>Your provider must obtain prior authorization for non-emergency transportation. | | $0 copay or 20% coinsurance for ground<br>$0 copay or 20% coinsurance for air |
| **Routine transportation** | | $0 copay for 36 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies |
| **Medicare Part B prescription drugs**<br>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Chemotherapy drugs[2] | $0 copay or 20% coinsurance |
| | Part B covered insulin[2] | $0 copay or 20% coinsurance, up to $35 |
| | Other Part B drugs[2]<br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | $0 copay or 20% coinsurance |

| Prescription drugs | |
|---|---|
| **If you don't qualify for Low-Income Subsidy (LIS), you pay the Medicare Part D cost-share outlined in the Evidence of Coverage. If you do qualify for Low-Income Subsidy (LIS) you pay:** | |
| **Deductible** | Your deductible amount is $0 |
| **Initial Coverage** | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,100, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. |

| Prescription drugs | |
|---|---|
| **Drug Coverage** | **30-day^ or 100-day supply from a retail network pharmacy** |
| Generic (including brand drugs treated as generic) | $0, $1.60, or $5.10 copay<br>Drugs that are in Tier 1 are always $0 copay.<br>(Some covered drugs are limited to a 30-day supply) |
| All other drugs[3] | $0, $4.90, or $12.65 copay<br>Drugs that are in Tier 1 are always $0 copay.<br>(Some covered drugs are limited to a 30-day supply) |
| **Catastrophic Coverage** | Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. |
| **Additional covered drugs**<br>These drugs are not covered by Medicare Part D and not on the plan's Drug List. | This plan covers these additional drugs as Tier 1 medications.<br>•Folic Acid (1 mg) |

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

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

| Additional benefits | | |
|---|---|---|
| **Chiropractic services** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[2] | $0 copay or 20% coinsurance |
| **Diabetes management** | Diabetes monitoring supplies[2] | $0 copay<br><br>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.<br><br>Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide. |

| Additional benefits | | |
|---|---|---|
| | | Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus. |
| | Diabetes self-management training | $0 copay |
| | Therapeutic shoes or inserts[2] | $0 copay or 20% coinsurance |
| **Durable medical equipment (DME) and related supplies** | DME (e.g., wheelchairs, oxygen)[2] | $0 copay or 20% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[2] | $0 copay or 20% coinsurance |
| **Fitness program** | | $0 copay<br>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:<br>• Free gym membership at core and premium locations<br>• Access to a large national network of gyms and fitness locations<br>• On-demand workout videos and live streaming fitness classes<br>• Online memory fitness activities |
| **Foot care** (podiatry services) | Foot exams and treatment[2] | $0 copay or 20% coinsurance |
| | Routine foot care | $0 copay, 8 visits per year |
| **Meal benefit[2]** | | $0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay |
| **Home health care[2]** | | $0 copay |
| **Hospice** | | 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. |
| **Opioid treatment program services[2]** | | $0 copay |

| Additional benefits | | |
|---|---|---|
| **Outpatient substance use disorder services** | Outpatient group therapy visit[2] | $0 copay or 20% coinsurance |
| | Outpatient individual therapy visit[2] | $0 copay or 20% coinsurance |
| **OTC, healthy food, utilities + wellness support** | | $133 credit every month for over-the-counter (OTC) products and wellness support, plus healthy food and utilities for qualifying members<br>•Choose from thousands of OTC products, like first aid supplies, pain relievers and more<br>•Buy healthy foods like fruits, vegetables, meat, seafood, dairy products and water<br>•Shop at thousands of participating stores, including Walmart, Walgreens and Dollar General, or at neighborhood stores near you<br>•Pay home utilities like electricity, heat, water and internet<br>•Get wellness support including in-home services, weight management coaching, respite care, select fitness items and more |
| **Renal dialysis[2]** | | $0 copay or 20% coinsurance |

[1] Requires a referral from your doctor.

[2] May require your provider to get prior authorization from the plan.

## Plan deductible

Your plan has a deductible for certain services. The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover.

The deductible applies to the following Medicare-covered benefit categories, unless otherwise specified.

### Annual medical deductible

Your deductible is $283 per year for covered medical services you receive from providers as described below. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.

**Here's how it works:**

1. You pay your plan's deductible in full; then,
2. You pay your copay or coinsurance; finally,
3. Your plan pays the rest.

The deductible applies in-network to the following Medicare-covered benefit categories, unless otherwise specified:

| In-network<br>List of applicable services |
|---|
| **Outpatient hospital**<br>• Ambulatory surgical center (ASC), excluding diagnostic colonoscopy<br>• Outpatient hospital, including surgery, excluding diagnostic colonoscopy<br>• Outpatient hospital observation services |
| **Doctor visits**<br>• Primary<br>• Specialists |
| **Diagnostic tests, lab and radiology services, and X-rays**<br>• Diagnostic radiology services (e.g. MRI), excluding diagnostic mammogram and in-home vascular screening<br>• Lab services<br>• Diagnostic tests and procedures<br>• Therapeutic radiology<br>• Outpatient X-rays |
| **Hearing services**<br>• Exam to diagnose and treat hearing and balance issues |
| **Vision services**<br>• Exam to diagnose and treat diseases and conditions of the eye<br>• Eyewear after cataract surgery |

**Mental health**
- Outpatient group therapy visit
- Outpatient individual therapy visit

**Physical therapy and speech and language therapy visit**

**Ambulance**

**Medicare Part B drugs**
- Chemotherapy drugs
- Other Part B drugs

**Chiropractic services**
- Manual manipulation of the spine to correct subluxation

**Diabetes management**
- Diabetes monitoring supplies
- Therapeutic shoes or inserts

**Durable medical equipment (DME) and related supplies**
- Durable medical equipment (e.g. wheelchairs, oxygen)
- Prosthetics (e.g., braces, artificial limbs)

**Foot care (podiatry services)**
- Foot exams and treatment

**Occupational therapy visit**

**Opioid treatment program services**

**Outpatient substance use disorder services**
- Outpatient group therapy visit
- Outpatient individual therapy visit

**Renal dialysis**

## 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 Ohio Department 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 Ohio Department of Medicaid - Medicaid Consumer Hotline, 1-800-324-8680, TTY 711.

| Benefits | Medicaid | UHC Dual Complete OH-D001 (HMO D-SNP) |
|---|---|---|
| **Inpatient Hospital Care** | Covered | Covered |
| **Doctor Office Visits** | Covered | Covered |
| **Preventive Care**<br>**Only limitation specific to Preventative Exams and Screenings: colonoscopies for individuals age 50 and older or high risk individuals** | Covered with limitations | Covered |
| **Emergency Care** | Covered | Covered |
| **Urgently Needed Services** | Covered | Covered |
| **Diagnostic Tests Lab and Radiology Services and X-Rays**<br>**Only limitation specific to mammography: One screening for women between the ages of 35-40, and then once every 12 month period thereafter** | Covered with limitations | Covered |
| **Hearing Services** | Covered | Covered |
| **Dental Services**<br>**Braces: Individuals younger than age 21; Checkups and cleanings: every 180 days (6 months) for individuals younger than age 21: every 365 days (12 months) for individuals age 21 and older** | Covered with limitations | Covered |

| Benefits | Medicaid | UHC Dual Complete OH-D001 (HMO D-SNP) |
|---|---|---|
| **Vision Services**<br>**One exam and eyeglasses every 12 months (individuals younger than age 21 and older than age 60). One exam and eyeglasses every 24 months (individuals between the ages of 21 and 59)** | Covered with limitations | Covered |
| **Inpatient Mental Health Care** | Covered | Covered |
| **Mental Health Care** | Covered | Covered |
| **Skilled Nursing Facility (SNF)** | Covered | Covered |
| **Ambulance** | Covered | Covered |
| **Transportation (Routine)** | Covered | Covered |
| **Prescription Drug Benefits**<br>**Part D eligilible beneficiaries can only receive Medicaid coverage for medications that are excluded from Medicare Part D coverage** | Covered with limitations | Covered |
| **Chiropractic Care**<br>**30 visits every 12 months for children younger than age 21: 15 visits every 12 months for adults older than age 21** | Covered with limitations | Covered with limitations |
| **Diabetes Supplies and Services** | Covered | Covered |
| **Durable Medical Equipment** | Covered | Covered |
| **Foot Care** | Covered | Covered |
| **Home Health Care** | Covered | Covered |
| **Hospice** | Covered | Covered |
| **Outpatient Hospital Services** | Covered | Covered |
| **Renal Dialysis** | Covered | Covered |
| **Prosthetic Devices** | Covered | Covered |
| **Additional Dental Services** | Covered | Covered |
| **Additional Foot Care** | Not covered | Covered |
| **Family Planning** | Covered | Covered with limitations |
| **Additional Vision Services** | Covered | Covered |
| **Home and Community! Based Services (HCBS)** | Covered | Not covered |
| **Over the Counter Items** | Covered | Covered |

| Benefits | Medicaid | UHC Dual Complete OH-D001 (HMO D-SNP) |
|---|---|---|
| **Physical Exam for Job Placement** | Covered | Not covered |
| **Prenatal and Postpartum Care** | Covered | Not covered |
| **Healthchek** | Covered | Not covered |
| **Alcohol and Drug Addiction** | Covered | Covered |
| **Acupuncture** | Covered | Covered with limitations |

## About this plan

UHC Dual Complete OH-D001 (HMO D-SNP) is a Medicare Advantage HMO 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.

This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and Medicaid. How much Medicaid covers depends on your income, resources, and other factors.

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.
- **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.
- **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 above. 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:

**Ohio:** Butler, Clark, Cuyahoga, Franklin, Greene, Hamilton, Madison, Mahoning, Montgomery, Stark, Summit, Trumbull, Warren.

## Use network providers and pharmacies

UHC Dual Complete OH-D001 (HMO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. This health plan requires you to select a primary care provider (PCP) from the network. Your PCP can handle most routine health care needs and will be responsible to coordinate your care. If you need to see a network specialist or other network provider, you may need to get a referral from your PCP. We encourage you to find out which specialists and hospitals your PCP would recommend for you and would refer you to for care, prior to selecting them as your plan's PCP. If you use providers or pharmacies that are not in our network, the plan may not pay for those services or drugs, or you may pay more than you pay at a network pharmacy.

You can go to **UHC.com/CommunityPlan** 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 OH-D001 (HMO 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 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 1-866-944-3488 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 1-866-944-3488, 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 2025.

**Fitness program**

The fitness benefit and gym network varies by plan/area and participating locations may change. The fitness benefit includes a standard fitness membership at participating locations. Not all plans offer access to premium locations. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.

**OTC, healthy food, utilities + wellness support**

OTC, food and utility benefits have expiration timeframes. Review your Evidence of Coverage (EOC) for more information. The healthy food and utilities benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as diabetes, cardiovascular disorders, chronic heart failure, chronic high blood pressure and/or chronic high cholesterol, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed. Certain wellness support services are provided by third parties not affiliated with UnitedHealthcare and participation may be subject to your acceptance of the third parties' respective terms and policies. UnitedHealthcare is not responsible for the services provided by third parties.

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

when necessary.

**Rewards Program**

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

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# 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**.

## Medicare Made Clear®

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

**MedicareMadeClear.com**

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# Before you enroll

It's important that you understand this Dual Special Needs Plan (D-SNP) and what benefits are covered. You can find the Drug List, Provider and Pharmacy directories, Evidence of Coverage and more at **UHC.com/CommunityPlan**.

**Are your drugs covered? Check the Drug List (Formulary) to make sure.**
Drugs not covered by the plan may have alternative covered drugs that can be used instead.

**Are your providers in the network?**
If your providers are not in the network, you will need to select a new network provider.

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

**Did you review the Summary of Benefits?**
These are just some of the benefits covered by the plan. You can find a complete list of coverage, costs, benefits and plan rules in the Evidence of Coverage online.

## You're eligible to enroll if:

You're enrolled in Original Medicare Parts A and B

You receive state Medicaid benefits

You 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 **UHC.com/CommunityPlan** or scan the code below to enroll online. Then follow these simple steps:

1. Enter your ZIP code
2. Navigate to the **Medicare Advantage** section
3. Look for the **UHC Dual Complete OH-D001 (HMO D-SNP)** plan and select the **Enroll** button
4. 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 send us a completed Enrollment Request Form. If you have a qualifying condition, complete the Additional Benefit Verification Form to use your OTC credit for healthy food and utilities.

**Scan this code to complete your enrollment online**

# What to expect after you enroll

Once you're a member, you can rely on UnitedHealthcare to support you every step of the way. 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 open doors to all your Medicare Advantage plan has to offer.

**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:

- Check the status of your enrollment
- Find network providers and pharmacies and view plan documents, like your Drug List (Formulary) and Evidence of Coverage
- Complete your health assessment

## Reach for your UCard when

- Visiting a provider or filling a prescription
- Paying for OTC products and more – including healthy food and utilities if you qualify. (We'll verify your qualifying condition with your doctor and send you a letter with next steps)
- Spending your earned rewards
- Checking in at the gym

## Once your coverage begins

- Schedule your annual physical and wellness visit
- You have access to an annual in-home Optum® HouseCalls visit and personalized care coordination from a care navigator as part of your health plan
- Review UCard balances

## Thank you for choosing UnitedHealthcare

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

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# 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
- ☐ Standalone Medicare prescription drug (Part D) plans
- ☐ Medicare Supplement (Medigap) products
- ☐ Dental, vision, hearing products
- ☐ Hospital indemnity 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:

| **Signature of beneficiary/authorized representative** | **Today's date** |
|---|---|
| | MM-DD-YYYY |

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

| Name (First and Last) | Relationship to beneficiary |
|---|---|
| | |

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

| Sales Agent name (First and Last) | Sales Agent phone | Sales Agent ID |
|---|---|---|
| | – – | |
| **Beneficiary name (First and Last)** | **Beneficiary phone** | **Date of appointment** |
| | – – | MM-DD-YYYY |

Beneficiary address

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

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.

# Additional Benefit Verification Form

To receive your healthy food and utilities benefit, we need to verify your qualifying condition(s). After you complete this form, please return it with your plan enrollment form. Do **not** take this form to your treating physician.

**Name:** _____

**Date of birth:** _____ **Medicare ID:** _____

## Qualifying clinical conditions

Please select the health condition(s) that apply to you:

- ☐ Diabetes mellitus (type 1 or type 2)
- ☐ Cardiovascular disorders
- ☐ Chronic heart failure
- ☐ Chronic hypertension (chronic high blood pressure)
- ☐ Chronic hyperlipidemia (chronic high cholesterol)
- ☐ Autoimmune disorders
- ☐ Cancer
- ☐ Chronic alcohol use disorder and other substance use disorders (SUDs)
- ☐ Chronic gastrointestinal disease
- ☐ Chronic kidney disease (CKD)
- ☐ Chronic lung disorders
- ☐ Chronic and disabling mental health conditions
- ☐ Dementia
- ☐ HIV/AIDS
- ☐ Immunodeficiency and immunosuppressive disorders
- ☐ Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
- ☐ Neurologic disorders
- ☐ Overweight, obesity and metabolic syndrome
- ☐ Post-organ transplantation care
- ☐ Severe hematologic disorders
- ☐ Stroke
- ☐ Conditions associated with cognitive impairment
- ☐ Conditions with functional challenges and require similar services including spinal cord injuries, paralysis, limb loss, stroke and arthritis

## Treating physician information

| Full name | Phone number | |
|---|---|---|
| Address | | |
| City | State | ZIP code |
| Fax number | Email address | |
| National Provider Identifier (NPI) number (10–12 digits without dashes) | | |

If you don't have all this information, you can complete your treating physician's full name and NPI number (exactly as it's found in the Provider Directory or online).

**Have you seen this provider within the last 2 years?** ☐ Yes ☐ No

## Authorization to release information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with federal law.

**I understand and agree that:**

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services or enrollment or eligibility for health care benefits if I do not sign this form;
- Once my health information is shared, the person or organization receiving it may share it again. If they are not a health plan or health care provider, the information may no longer be protected by federal privacy laws; and
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not influence any actions taken before the date my revocation is received and processed.

**Who may receive and disclose my information:**

I authorize UnitedHealth Group's subsidiaries and their affiliates to receive from or disclose my individually identifiable health information between and among themselves.

**Type of information to be disclosed:**

I authorize disclosure of all my health information including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.

**Purpose of disclosure:**

My health information is being disclosed to verify that I qualify for the healthy food and utilities benefit or to verify my diagnosis of a covered chronic condition.

| **Applicant signature** | **Date** |
|---|---|
| | |

| **Witness signature (For Illinois residents only)** | **Date** |
|---|---|
| | |

**Please note: If you are a guardian or court appointed representative, please complete the fields on the following page and attach a copy of your legal authorization to represent the member.**

| **Guardian or Representative:** | | |
|---|---|---|
| Name | Phone number | |
| Street address | | |
| City | State | ZIP code |
| Guardian or Representative signature | | Date |

For California and Georgia residents only: I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

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

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# 2026 Enrollment Request Form

☐ **UHC Dual Complete OH-D001 (HMO D-SNP) H5253-059-000**

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

| Last name | First name | Middle initial |
|---|---|---|
| | | |

| Birth date | Sex ☐ Male ☐ Female |
|---|---|
| Home phone number ( ) — | Mobile phone number ( ) — |

You can stay on top of your plan and health with timely, helpful calls.
☐ Check here to consent to receive calls using auto dialer/artificial or prerecorded voice technology. You can change your preference at any time.

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 P.O. 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

You will receive some plan information, such as your Explanation of Benefits and Annual Notice of Changes, electronically (quicker than mail). We'll email you when new documents are ready to review online.
☐ Check here if you prefer to receive paper copies by mail. You can change your delivery preference at any time.

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__/__/__/__/__/__/__/__/__/__

*Members enrolled in the EFT program agree to these terms: My bank may pay UnitedHealthcare Insurance Company the new charges from my bank Account which may include up to $200.00 of current retroactive charges plus monthly premium amount. If I choose to stop paying by EFT, I will tell both UHC and my bank. I understand it could take 1-2 months to process the change.

## A few questions to help us manage your plan

**1. Which language or accessible format do you prefer for future plan information?**

Enrollee name _____

Agent name/ID number _____

☐ English ☐ Spanish

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

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 **UHC.com/CommunityPlan** for online help. **If no selection is made, you will receive plan information in English.**

**2. Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

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

**3. Do you or your spouse work?** ☐ Yes ☐ No

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

**4. 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

## 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 (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.

Enrollee name _____

Agent name/ID number _____

- ☐ 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 | |

## For individuals helping enrollee with completing this form only

Enrollee name _____

Agent name/ID number _____

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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**

☐ IEP (MA-PD enrollees)
☐ ICEP (MA enrollees)
☐ IEP (MA-PD enrollees eligible for 2nd IEP)
☐ OEP (Jan 1 – Mar 31)
☐ OEP (Newly eligible)
☐ SEP (Dual LIS change of status)
☐ SEP (Change in residence)
☐ SEP (Loss of EGHP coverage)
☐ SEP (Chronic)
☐ SEP (Dual LIS maintaining)
☐ AEP (October 15-December 7)
☐ OEPI
☐ SEP (SEP reason) _____

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

**Please mail or fax this completed form to:**
UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770
Fax: 1-888-950-1170
Fax the front and back of each page

Enrollee name _____
Agent name/ID number _____

**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 OH-D001 (HMO 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.

OMB No. 0938-1378
Expires: 12/31/2026
Y0066_EFMA_2026_C CSOH26HM0320864_000

# 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.
- ✔ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ✔ 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.

# 2026 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 UCard®. This receipt is not a guarantee of enrollment.

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

| **Applicant 1:** | **Applicant 2 (if applicable):** |
|---|---|
| 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**

**RxPCN: 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.

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# Important information: 2026 Medicare star ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

## UnitedHealthcare - H5253

For 2026, UnitedHealthcare - H5253 received the following Star Ratings from Medicare:

| | | |
|---|---|---|
| Overall Star Rating: | ★ ★ ★ ★ | 4 stars |
| Health Services Rating: | ★ ★ ★ ★ | 4 stars |
| Drug Services Rating: | ★ ★ ★ ★ | 4 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**.

### 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 Sunday through Friday from 8:00 a.m. to 8:00 p.m. Local time. Current members please call **866-944-3488** (toll-free) or **711** (TTY).

## Notice of nondiscrimination

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
1 Optum Circle
Eden Prairie, MN 55344

**Optum_Civil_Rights@Optum.com**

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**
**https://www.optum.com/en/language-assistance-nondiscrimination.html**

## 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.

**ማሳሰቢያ፡- አማርኛ** (Amharic) የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

**ملاحظة**: إذا كنت تتحدث **اللغة العربية** (Arabic)، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على 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 Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

**ध्यान दें**: यदि आप **हिंदी** (Hindi) बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

**注意事項**：**日本語** (Japanese) を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

**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.

**लक्ष द्या**: जर तुम्ही **मराठी** (Marathi) बोलत असल्यास, तर मोफत भाषा सहाय्य सेवा आणि इतर फॉरमॅटमध्ये मोफत संप्रेषणे, जसे की मोठ्या प्रिंट, तुमच्यासाठी उपलब्ध आहेत. तुमच्या सदस्य ओळखपत्रावरील टोल फ्री क्रमांकावर कॉल करा.

**ध्यान दिनुहोस्**: यदि तपाईंले **नेपाली** (Nepali) बोल्नुहुन्छ भने, नि:शुल्क भाषा सहायता सेवाहरू र अन्य ढाँचाहरूमा नि:शुल्क संचारहरू, जस्तै ठूलो छाप, तपाईंका लागि उपलब्ध छन्। आफ्नो सदस्य पहिचान कार्डमा रहेको टोल फ्री नम्बरमा कल गर्नुहोस्।

**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 **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación 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.

**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 nói **Tiếng Việt** (Vietnamese), quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn 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 có trên thẻ định danh thành viên của quý vị.

**אויפמערק**: אויב איר רעדט **אידיש** (Yiddish), קענט איר באקומען אומזיסטע שפראך הילף סערוויסעס און אומזיסטע קאמיוניקאציע אויף אנדערע פארמאטן, אזוי ווי גרויסע אותיות. רופט דעם אומזיסטן נומער אויף אייער מעמבער אידענטיפיקאציע קארטל.

**ÀKÍYÈSÍ**: Tí o bá ń ṣọ **Yorùbá** (Yoruba), àwọn iṣẹ́ àtìlẹ́yìn èdè ọ̀fẹ́ àti àwọn ìbánisọ̀rọ̀ nínú àwọn ìgúnrégé, bí àwọn àtẹ̀jáde ńlá, wà fún ọ. Pe nọ́mbà tí kò nílò owó lórí káàdì ìdánimọ̀ ọmọ ẹgbẹ́ rẹ.

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# Notes and doodles

# Ready to use your extra benefits?

## UHC Dual Complete OH-D001 (HMO D-SNP)

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

Call **1-866-944-3488**, 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: MARCH® Vision Care
- ☐ Routine dental benefits: UnitedHealthcare Dental
- ☐ Fitness program: Renew Active®

**Hearing aids**
UnitedHealthcare Hearing
1-855-523-9355
UHCHearing.com/Medicare

**Prescription drug home delivery**
Optum® Home Delivery Pharmacy
1-877-889-6358
MyUHC.com/CommunityPlan

**Routine transportation**
SafeRide
1-888-462-6048
myUHC.com/CommunityPlan

**OTC, healthy food, utilities + wellness support**
Solutran
1-833-845-8798
myUHC.com/CommunityPlan

UnitedHealthcare has more than 45 years of experience serving members.
You can count on UnitedHealthcare to be there for you every step of the way.

## Click. Call. Connect.

Download the UnitedHealthcare app

**UHC.com/CommunityPlan**

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

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

Important plan information

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