

2027

# Paper Enrollment Forms

**UHC Complete Care Support MI-3 (PPO C-SNP)**

H0294-048-000

**Service area:** Michigan - Allegan, Antrim, Arenac, Bay, Benzie, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Crawford, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Iosco, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Livingston, Manistee, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, Wexford counties



This page left intentionally blank.

# Summary of Benefits 2027

**UHC Complete Care Support MI-3 (PPO C-SNP)**

H0294-048-000

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

Download the **UnitedHealthcare app**

Visit **UHC.com/Medicare**

Call toll-free **1-866-367-7527**, TTY **711**
8 a.m.-8 p.m. local time, 7 days a week

UnitedHealthcare®

Y0066_SB_H0294_048_000_2027_M

# Summary of Benefits

## January 1, 2027 - December 31, 2027

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 **myUHCMedicare.com** 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 Complete Care Support MI-3 (PPO C-SNP)

| **Medical premium, deductible and limits** | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Monthly plan premium** | $0<br>You need to continue to pay your Medicare Part B premium | |
| **Annual medical deductible** | This plan does not have a medical deductible. | |
| **Maximum out-of-pocket amount** (does not include prescription drugs) | $7,150<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>Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount. | $10,750<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from any provider. |

| **Medical benefits** | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Inpatient hospital care**[2]<br>Our plan covers an unlimited number of days for an inpatient hospital stay. | | $455 copay per day: days 1-6<br>$0 copay per day: days 7 and beyond | $455 copay per day: for days 1-6<br>$0 copay per day: for days 7 and beyond |
| **Outpatient hospital**<br>Cost-sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC)[2] | $0 copay for a colonoscopy<br>$455 copay otherwise | $0 copay for a colonoscopy<br>$455 copay otherwise |
| | Outpatient hospital, including surgery[2] | $0 copay for a colonoscopy<br>$455 copay otherwise | $0 copay for a colonoscopy<br>$455 copay otherwise |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Outpatient hospital observation services[2] | $455 copay | $455 copay |
| **Doctor visits** | Primary care provider | $0 copay | $0 copay |
| | Specialists[2] | $55 copay | $55 copay |
| | Virtual medical visits | $0 copay | Same as a Doctor's office visit |
| **Preventive services** | Routine physical | $0 copay, 1 per year* | $0 copay, 1 per year* |
| | Medicare-covered | $0 copay | $0 copay |
| | • 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<br>• "Welcome to Medicare" preventive visit (one-time)<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** | | $130 copay 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. | |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Urgently needed services** | | $50 copay 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>$285 copay otherwise | $0 copay for each diagnostic mammogram<br>$285 copay otherwise |
| | Lab services[2] | $0 copay | $0 copay |
| | Diagnostic tests and procedures[2] | $60 copay | $60 copay |
| | Therapeutic radiology[2] | 20% coinsurance | 20% coinsurance |
| | Outpatient X-rays[2] | $25 copay | $25 copay |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues[2] | $0 copay | $55 copay |
| | Routine hearing exam | $0 copay for a routine hearing exam to help support hearing health* | $55 copay for a routine hearing exam to help support hearing health* |
| | Hearing aids[2] | $700 allowance for 2 hearing aids every year*<br>• A broad selection of 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 | If you use an out-of-network provider, you are responsible for 90% of the allowance amount.* |
| **Routine dental benefits** | Preventive services | $0 copay for covered preventive services like oral exams, X-rays, routine cleanings and fluoride*<br>• No annual deductible<br>• Access to one of the largest national dental networks<br>• Freedom to see any dentist | |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Optional Dental Rider | For an extra $54 per month, you'll get access to dental coverage that includes:<br>• $1,500 per year for covered dental services through the Platinum Dental Rider*<br>• $0 copay for covered network preventative services such as exams, routine cleanings, X-rays and fluoride<br>• 50% coinsurance for all covered network comprehensive services such as fillings, crowns, root canals, dentures, bridges and extractions | |
| **Vision services** See the **Member discounts** section for related offers | Exam to diagnose and treat diseases and conditions of the eye[2] | $0 copay | $0 copay |
| | Eyewear after cataract surgery | $0 copay | $0 copay |
| | Routine eye exam | $0 copay for a routine eye exam each year to help protect your eyesight and health* | $0 copay for a routine eye exam each year to help protect your eyesight and health* |
| **Mental health** | Inpatient visit[2]<br>Our plan covers 90 days for an inpatient hospital stay | $455 copay per day: days 1-5<br>$0 copay per day: days 6-90 | $455 copay per day: days 1-5<br>$0 copay per day: days 6-90 |
| | Outpatient group therapy visit[2] | $15 copay | $15 copay |
| | Outpatient individual therapy visit[2] | $25 copay | $25 copay |
| | Virtual mental health visits | $0 copay | Same as an Outpatient mental health office visit |
| **Skilled nursing facility (SNF)[2]**<br>Our plan covers up to 100 days in a SNF. | | $0 copay per day: days 1-20<br>$221 copay per day: days 21-100 | $0 copay per day: days 1-20<br>$221 copay per day: days 21-100 |
| **Outpatient rehabilitation services** | Physical therapy and speech and language therapy visit[2] | $50 copay | $50 copay |
| | Occupational Therapy Visit[2] | $50 copay | $50 copay |
| **Ambulance[2]** | | $400 copay for ground | $400 copay for ground |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| Your provider must obtain prior authorization for non-emergency transportation. | | $400 copay for air | $400 copay for air |
| **Medicare Part B prescription drugs** In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Chemotherapy drugs[2] | 20% coinsurance | 20% coinsurance |
| | Part B covered insulin[2] | 20% coinsurance; up to $35 | 20% coinsurance |
| | Other Part B drugs[2] Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | $0 copay for allergy antigens<br>20% coinsurance for all others | $0 copay for allergy antigens<br>20% coinsurance for all others |

## What is coinsurance?

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 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.

| Prescription drug payment stages | | | |
|---|---|---|---|
| **Deductible** | There is no deductible for drugs in Tier 1 and 2. Your coverage for these drugs starts in the Initial Coverage stage.<br>There is a $700 deductible for drugs in Tier 3, 4 and 5. You pay the full cost for your drugs in these tiers until you reach the deductible amount. Then you move to the Initial Coverage stage. | | |
| **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 $2,400, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. | | |
| **Tier drug coverage** | **Retail** | | **Mail Order** |
| | **30-day supply^** | **100-day supply** | **100-day supply** |
| **Tier 1:** Preferred Generic | $0 copay | $0 copay | $0 copay |
| **Tier 2:** Generic | $3 copay | $9 copay | $9 copay |
| **Tier 3:** Preferred Brand | 25% coinsurance | 25% coinsurance | 25% coinsurance |
| Covered Insulin Drugs[4] | 25% coinsurance, up to $35 copay | 25% coinsurance, up to $105 copay | 25% coinsurance, up to $105 copay |
| **Tier 4:** | 25% coinsurance | N/A | N/A |

| Prescription drug payment stages | | | |
|---|---|---|---|
| Non-Preferred Drug[5] | | | |
| **Tier 5:** Specialty Tier[5] | 25% coinsurance | N/A | N/A |
| **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. | | |

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

[4]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.

[5]Limited to a 30-day supply

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Chiropractic services** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[2] | $15 copay | $15 copay |
| **Diabetes management** | Diabetes monitoring supplies[2] | $0 copay<br>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.<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.<br>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Check Aviva Plus. | 50% coinsurance |
| | Diabetes self-management training | $0 copay | $0 copay |
| | Therapeutic shoes or inserts[2] | $0 copay | 50% coinsurance |

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Durable medical equipment (DME) and related supplies** | DME (e.g., wheelchairs, oxygen)[2] | 20% coinsurance | 50% coinsurance |
| | Prosthetics (e.g., braces, artificial limbs)[2] | 20% coinsurance | 50% coinsurance |
|  **Fitness program** | | $0 copay<br>Your fitness program helps you stay active and connected at the gym or in your community. It's available to you at no additional cost and includes:<br>• Free gym membership at core and premium locations<br>• Access to a large national network of gyms and fitness locations | If you use an out-of-network provider, you pay 90% of the total cost |
| **Foot care** (podiatry services) | Foot exams and treatment[2] | $50 copay | $50 copay |
| | Routine foot care | $50 copay, 6 visits per year* | |
| **Home health care[2]** | | $0 copay | 50% coinsurance |
| **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 | $0 copay |
| **Outpatient substance use disorder services** | Outpatient group therapy visit[2] | $15 copay | $15 copay |
| | Outpatient individual therapy visit[2] | $25 copay | $25 copay |

| Additional plan benefits | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **OTC and food credit** | $41 credit every month for over-the-counter (OTC) products, plus healthy food for qualifying members<br>• Choose from thousands of OTC products, like first aid supplies, pain relievers and more<br>• Buy healthy foods like fruits and vegetables, meat and seafood, dairy products and bottled water<br>• Shop at thousands of participating stores, including Walmart, Walgreens, Dollar General, Target, and at neighborhood stores near you | If you use an out-of-network store, you pay 90% of the total cost |
| **Renal dialysis**[2] | 20% coinsurance | 20% coinsurance |

[2] May require your provider to get prior authorization from the plan for in-network benefits.

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

| Optional supplemental benefits | |
|---|---|
| **Platinum Dental Rider premium** | Additional $54 per month<br><br>The Platinum Dental Rider includes preventive and comprehensive dental benefits. It can be purchased to replace any dental benefits that may already be offered within your Medicare Advantage Plan. |

## Member discounts

As a UnitedHealthcare Medicare Advantage plan member, you'll have access to a collection of discounts on hundreds of products and services such as eyewear. Once you're a member, you can sign in to your member site for a list of discounts available to you.

## About this plan

UHC Complete Care Support MI-3 (PPO C-SNP) is a Medicare Advantage PPO 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.

UHC Complete Care Support MI-3 (PPO C-SNP) is a Chronic or Disabling Condition Special Needs Plan designed to specifically help people who have one or more of the following conditions: Cardiovascular Disorders, Chronic Heart Failure, and Diabetes.

Our service area includes these counties in:

**Michigan:** Allegan, Antrim, Arenac, Bay, Benzie, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Crawford, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Huron, Ingham, Iosco, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Lapeer, Leelanau, Livingston, Manistee, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, Wexford.

## Use network providers and pharmacies

UHC Complete Care Support MI-3 (PPO C-SNP) has a network of doctors, hospitals, pharmacies and other providers. With this plan, you have the freedom to enjoy access to care at in-network costs when you visit any provider participating in the UnitedHealthcare® Medicare National Network (exclusions may apply). Plus, you have the flexibility to visit any provider nationwide who accepts Medicare. You may pay a higher copay or coinsurance when you see an out-of-network provider. When looking at the charts above you'll see the cost differences for network vs. out-of-network care and services. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **UHC.com/Medicare** 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 Complete Care Support MI-3 (PPO C-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. 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.

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

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party. Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

**Hearing aids -** The plan may only cover hearing aids from a UnitedHealthcare Hearing network provider. Other hearing exam providers are available in the UnitedHealthcare network.

**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 benefits and gym networks vary by plan/area and participating locations may change. The fitness benefit includes a standard fitness membership at participating locations. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.

**Member discounts -** As a UnitedHealthcare Medicare Advantage plan member, you'll have access to an exclusive collection of discounts on hundreds of products and services. Once you're a member, you can sign in to your member site for a list of discounts available to you. The discounts described are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process. Discount offerings may vary by plan and are not available on all plans. The discount offers are made available to members through a third party. Participation in these third-party discount offers is subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties.

**Rewards Program -** 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**. Members must participate January through December to earn all available rewards. Rewards must be earned and reported within time frames specified by the plan.

This page left intentionally blank.

# 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 types of plans 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 permit the 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.

# Chronic Condition Pre-assessment Form

To enroll in a Chronic Special Needs plan, Medicare requires that your chronic condition be verified by your treating physician's office. We also need this information to verify that you qualify for the healthy food benefit.

Please answer the questions below and complete the information requested on the following pages so we may have your treating physician verify your chronic condition. After you complete this form, please return it with your plan enrollment form. Do **not** take this form to your treating physician.

**Clinical pre-qualify questions**

This is a pre-assessment. Post-verification by your treating physician will occur after you are enrolled in the plan.

**Please answer these questions:**

**I. Diabetes mellitus** (Note: A pre-diabetes diagnosis does not qualify for this plan.)

1. Has a doctor or clinic told you that you have diabetes (too much sugar in the blood or urine or high sugar(s))? ☐ Yes ☐ No
2. Have you been prescribed or are you taking insulin or an oral medication for diabetes treatment? ☐ Yes ☐ No

---

**II. Chronic heart failure**

1. Has a doctor or clinic told you that you have chronic or congestive heart failure (fluid or water in the lungs or heart)? ☐ Yes ☐ No
2. Have you previously experienced fluid in your lungs, leg swelling and shortness of breath due to a heart problem? ☐ Yes ☐ No
3. In the past year, have you been advised by a health care professional to weigh yourself daily for heart monitoring? ☐ Yes ☐ No

---

**III. Cardiovascular disorders**

1. Have you been diagnosed with an irregular heart rate (like atrial fibrillation), heart disease or coronary artery disease? ☐ Yes ☐ No
2. Have you been told you have peripheral vascular disease, poor circulation or claudication in your legs? ☐ Yes ☐ No
3. Do you have chronic skin ulcers or leg vein problems? ☐ Yes ☐ No
4. Have you been prescribed blood thinners like warfarin or clopidogrel for a heart condition? ☐ Yes ☐ No
5. Do you have a pacemaker or internal defibrillator? ☐ Yes ☐ No
6. Have you had an angioplasty, stents or bypass surgery on your heart or legs? ☐ Yes ☐ No

***Completing this pre-assessment does not guarantee enrollment in the plan. All Chronic Special Needs plans require verification from a treating physician for enrollment in the plan.***

## 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 provide 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 or health insurance companies 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. However, if I do not sign this form, UnitedHealthcare may not be able to get information needed and may not be able to use another source to verify that I qualify for the healthy food benefit, and I may not be able to receive this benefit unless eligibility can be verified through another source. Also, I may not be able to exchange certain health information with my network providers, my previous health insurance company, or third parties named herein to better coordinate my healthcare and coverage;
- Once my health information is shared, the person or organization receiving it may share it again. If they are not a health plan, health insurance company or health care provider, the information may no longer be protected by federal privacy laws; and
- This authorization will expire 2 years from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing, by updating my consent-sharing preference on the member site or by calling Customer Service; however, the revocation will not influence any actions taken before the date my revocation is received and processed or any action taken pursuant to reliance on the authorization before the revocation became effective.

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

I authorize UnitedHealthcare and its subsidiaries and affiliates to receive from or disclose my individually identifiable health information between and among themselves, my health care providers, my previous health insurance companies, and with vendors that help assess eligibility for benefits and services such as healthy food.

If I haven't already provided my previous health insurance company's name and my member number, I can submit it on the member site.

**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 benefit or to verify my diagnosis of a covered chronic condition
- Help keep my health records complete and support my care by:
  - Requesting and sharing information with other health insurance companies I may have coverage with
  - Requesting health information from my previous health insurance company
  - Sharing health information with my network health care providers so they can work together on my care

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

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

**Please note: If you are a guardian or court appointed representative, please complete the Guardian or Representative fields 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 benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, who also meet plan criteria indicating they are at high risk for hospitalization and eligible for intensive care coordination. Contact us for details.

Y0066_CCVF_2027_C UHEX27SC0438269_000

United Healthcare®

# 2027 Enrollment Request Form

☐ **UHC Complete Care Support MI-3 (PPO C-SNP) H0294-048-000**

## Select optional supplemental benefits in addition to what is included with your plan

You can add the following benefit rider for an extra cost. You can purchase the rider now while you are enrolling, or within 3 months after your effective date. See the Summary of Benefits for more information, including costs.

☐ **Platinum Dental Rider**

## 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 ( ) — |

Stay on top of your plan and health with timely, helpful texts and calls. You can change your preferences at any time.

Check here to consent to receive texts from UnitedHealthcare at the mobile phone number you provided about:

- ☐ Important benefit information to help you manage your plan
- ☐ Reminders about preventive care or health screenings

You also agree to the texting terms and conditions at **uhc.com/txt-tcs**. Message frequency varies. Message and data rates may apply. Text STOP to opt out of a texting program.

☐ Check here to consent to receive calls from UnitedHealthcare and its affiliates at the phone number(s) you provided. This includes calls made using an autodialer or an artificial prerecorded voice.

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)**

Enrollee name _____

Agent name/ID number _____

| 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.

**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) |
|---|---|---|---|

Enrollee name _____

Agent name/ID number _____

**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?**

☐ 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 **1-866-367-7527**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/Medicare** for online help. **If no selection is made, you will receive plan information in English.**

**2. Have you served in the U.S. military?** ☐ Yes ☐ No

**3. If yes, have you received care or services from a VA hospital or clinic?** ☐ Yes ☐ No

Enrollee name _____

Agent name/ID number _____

**4. 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 other health insurance company

Member number for other health insurance

Payer ID for other health insurance

Do you give us permission to request and share your health information with the other health insurance company you listed above? ☐ Yes ☐ No

If yes, we'll request your records and share them with your other plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

**5. Do you give us permission to request your health information from your previous health insurance company?** ☐ Yes ☐ No

If yes, we'll request your records from your previous plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

If yes, please complete the following:

Name of previous health insurance company

Member number for previous health insurance company

Payer ID for previous health insurance company

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

You aren't limited to this list. You may go to any doctor who accepts Medicare and the plan's payment terms.
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

Enrollee name _____
Agent name/ID number _____

**7. Do you give us permission to share your health information with your providers?**
☐ Yes ☐ No

If yes, we'll share your health information with your providers so they can work together on your care. If no, your provider may still access some information as allowed by law to make sure you get the right care. You can change your preference at any time by calling Customer Service. If you don't make a selection now, we'll automatically share your information with your providers.

## 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.
- 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.
- 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 member ID card, I can call Customer Service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

Enrollee name _____
Agent name/ID number _____

**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

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, please select a qualifying election period for this enrollment**

| | | | |
|---|---|---|---|
| ☐ 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) |

Enrollee name _____

Agent name/ID number _____

☐ SEP (Chronic) ☐ SEP (Integrated Care) ☐ AEP (Oct 15- Dec 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

**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 Complete Care Support MI-3 (PPO C-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

OMB No. 0938-1378
Expires: 02/28/2029

# 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.

## 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.
- ✔ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network.
- ✔ 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. This premium is normally taken out of your Social Security check each month.
- ✔ Benefits may change on January 1 of each year.
- ✔ Our plan allows you to see providers outside of our network (non-contracted providers). Check the EOC to see which out-of-network services are covered on this plan. However, while we will pay for covered services the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay higher cost sharing for services received by non-contracted providers.
- ✔ 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 Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.

# 2027 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 member ID card. 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 local Licensed Sales Representative if you have any questions:** | **RxBIN: 610097**<br>**RxPCN: 9999**<br>**RxGRP: COS** |
|---|---|
| Representative name and ID number | |
| Representative phone number | |

**We're here to help.** If you have additional questions, please call UnitedHealthcare Customer Service toll-free at **1-866-367-7527**, TTY **711**, 8 a.m.–8 p.m. local time, 7 days a week.

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

# Important information: 2026 Medicare star ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

## UnitedHealthcare - H0294

For 2026, UnitedHealthcare - H0294 received the following Star Ratings from Medicare:

| | | |
|---|---|---|
| Overall Star Rating: | ★ ★ ★ ½ | 3.5 stars |
| Health Services Rating: | ★ ★ ★ ½ | 3.5 stars |
| Drug Services Rating: | ★ ★ ★ | 3 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 **800-555-5757** (toll-free) or **711** (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Local time. Current members please call **877-370-4876** (toll-free) or **711** (TTY).

# 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.

**দেখুন**: আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

**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.

ATTENZIONE: se parla **italiano (Italian)**, può 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.

**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.

**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.

**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.

ZINGATIA: Ikiwa unazungumza **Kiswahili (Swahili)**, huduma za usaidizi wa lugha za bila malipo na mawasiliano ya bila malipo katika miundo mingine, kama vile maandishi makubwa, zinapatikana kwako. Piga nambari isiyolipishwa ya simu kwenye kadi yako ya kitambulisho cha mwanachama.

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.