WHAT YOU NEED TO KNOW ABOUT YOUR MEDICARE ADVANTAGE PLAN.

2017 Medicare Part C Enrollment Guide

Erickson Advantage® Signature without Drugs (HMO-POS)

H5652-002

Service Area: Select counties in Colorado, Kansas, Maryland, Massachusetts, Michigan, New Jersey, Pennsylvania, Texas, Virginia

Plan Effective Date: January 1, 2017 through December 31, 2017
Discover a plan that
WORKS TO YOUR ADVANTAGE.

When it comes to staying active, you can choose from many activities. And when it comes to helping you stay healthy, look to Erickson Advantage. We believe you deserve more than just a health care plan. As a plan member, you’ll have a local health team dedicated to helping you live a healthier life.

We want to:

- Help you get the care you may need when you need it
- Give you tools and resources to help you be in more control of your health
- Provide additional benefits and resources so you can spend your time and money on things that matter most to you

In this Enrollment Guide you will find:

- A description of this plan and how it works
- Information on benefits, programs and services — and how much they cost
- Details on how to enroll and what you can expect after you enroll

Take advantage of healthy extras.

Enroll in three simple steps.

1. Find the Enrollment Request Form in the “Ready to Enroll” section of this Enrollment Guide.
2. Fill out the form(s) completely — make sure you sign and date it.
3. Send your completed form(s) back before your enrollment period ends.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan’s contract renewal with Medicare.
You’re enrolled in Original Medicare, what’s next?

Original Medicare is provided by the government and covers some of the costs of hospital stays (Part A) and doctor visits (Part B), but doesn’t cover everything—you don’t get coverage for prescription drugs or for routine vision, dental or hearing care. Depending on your needs, you may want to add on more coverage. When it comes to extra coverage, you have options.

Your options for more coverage:

Add one or both of the following to Original Medicare:

**OPTION 1**

**Medicare Supplement Insurance**
Offered by private companies

Covers some of the costs not paid by Original Medicare (Parts A and B)

**Medicare Part D**
Offered by private companies

Part D covers prescription drugs

**OPTION 2**

Choose a Medicare Advantage plan:

**Medicare Advantage (Part C)**
Offered by private companies

Part C combines Part A (hospital) and Part B (doctor)

Provides additional benefits

**Medicare Made Clear™ brought to you by UnitedHealthcare®**
Making Your Medicare PLAN CHOICE

This is a Part C Health Maintenance Organization – Point of Service (HMO-POS) plan.

Your plan is a Health Maintenance Organization – Point of Service (HMO-POS) plan. That means you can receive care through a network of local doctors and hospitals. Your primary care provider (PCP) may oversee your care. However, this plan gives you the option to receive some services from doctors or hospitals that are not in the plan’s network, usually at a higher cost to you.

Here’s how your HMO-POS plan works.

You must select a primary care provider (PCP).
This health plan requires you to select a PCP from the plan’s network who can help manage your care.

There’s no need to get referrals to see a specialist.
You can see any specialist in or out of our network for covered services.

There’s an out-of-pocket spending limit for in-network care.
Once you reach that limit, the plan pays 100% of the costs for in-network covered service for the rest of the plan year. Some plans have an out-of-pocket spending limit for out-of-network care.

Stay in the network for lower costs.

<table>
<thead>
<tr>
<th>Will the doctor or hospital accept my plan?</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>Providers have the choice to accept plan (except for emergencies).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are emergency or urgently needed services covered?</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do I have to pay the full cost for all covered doctor or hospital services?</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan co-pay or co-insurance applies.</td>
<td></td>
<td>You may pay a higher co-pay or co-insurance.</td>
</tr>
</tbody>
</table>

Plan co-pay or co-insurance are for those with 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. As a member, you will receive a Provider Directory listing all network providers and facilities within your plan. You can also find a complete listing on our website or you can request a Provider Directory from Customer Service. Limitations, exclusions, and restrictions may apply.
Are you eligible for this plan?

You are eligible for a Medicare Advantage plan if:

☑️ You are enrolled in Original Medicare Parts A and B and live in the plan’s service area

AND

☑️ You do not have end-stage renal disease.

Are there special eligibility requirements for this plan?

No, as long as you are enrolled in Original Medicare Parts A and B and continue to pay your Part B premium, you are eligible to enroll in this plan.

Helpful resources.

Medicare Made Clear™
An educational program developed by UnitedHealthcare to help the public better understand Medicare. Find out more at MedicareMadeClear.com.

Medicare Helpline
For questions about Medicare and detailed information about plans and policies available in your area, visit Medicare.gov or call Medicare at 1-800-633-4227, TTY 1-877-486-2048, 24 hours a day, 7 days a week.
Plan INFORMATION
Benefit Highlights
Erickson Advantage® Signature without Drugs (HMO-POS)

This is a short description of 2017 plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan Costs
- Monthly plan premium: $138

Medical Benefits

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor's office visit</td>
<td>Primary Care Provider: $0 co-pay</td>
<td>Primary Care Provider: 30% of the cost</td>
</tr>
<tr>
<td></td>
<td>Specialist: $35 co-pay (no referral needed)</td>
<td>Specialist: 30% of the cost (no referral needed)</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0 co-pay</td>
<td>$0 co-pay - 30% of the cost (depending on the service)</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>$0 co-pay per day for unlimited days</td>
<td>30% of the cost per admit</td>
</tr>
<tr>
<td>Skilled nursing facility (SNF)</td>
<td>$0 co-pay per day: days 1-20 $75 co-pay per day: days 21-87 $0 co-pay per day: days 88-100</td>
<td>30% of the cost per admit, up to 100 days</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>$50 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Diabetes monitoring</td>
<td>20% of the cost</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Home health care</td>
<td>$0 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Diagnostic radiology services (such as MRIs, CT scans)</td>
<td>$50 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Diagnostic tests and procedures (non-radiological)</td>
<td>$0 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Lab services</td>
<td>$0 co-pay</td>
<td>$0 co-pay</td>
</tr>
<tr>
<td>Outpatient x-rays</td>
<td>$20 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$150 co-pay</td>
<td>$150 co-pay</td>
</tr>
<tr>
<td>Emergency care</td>
<td>$50 co-pay (worldwide)</td>
<td></td>
</tr>
<tr>
<td>Urgently needed services</td>
<td>$30 co-pay ($50 co-pay for worldwide coverage)</td>
<td></td>
</tr>
<tr>
<td>Annual out-of-pocket maximum*</td>
<td><strong>$5,000 In-Network</strong></td>
<td>Unlimited Out-of-Network</td>
</tr>
</tbody>
</table>

*The most you may pay in a year for medical care covered by the plan.

Benefits and Services Beyond Original Medicare

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physical</td>
<td>$0 co-pay; 1 per year*</td>
<td>30% of the cost; 1 per year*</td>
</tr>
<tr>
<td>Vision - routine eye exams</td>
<td>$35 co-pay; 1 every year*</td>
<td>30% of the cost; 1 every year*</td>
</tr>
<tr>
<td>Vision - eyewear</td>
<td>$0 co-pay every 2 years; up to $100 for lenses/frames and contacts*</td>
<td>$0 co-pay every 2 years; up to $100 for lenses/frames and contacts*</td>
</tr>
<tr>
<td>Service</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Dental - preventive</td>
<td>$35 co-pay for office visit (includes exam, cleaning, x-rays)</td>
<td>No coverage</td>
</tr>
<tr>
<td>Foot care - routine</td>
<td>$0 co-pay; 6 visits per year*</td>
<td>30% of the cost; 6 visits per year*</td>
</tr>
<tr>
<td>Hearing - routine exam</td>
<td>$20 co-pay; 1 per year*</td>
<td>30% of the cost; 1 per year*</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>$330 - $380 co-pay for each hearing aid, up to 2 per year (Additional fees with Power Max model)</td>
<td>No coverage</td>
</tr>
<tr>
<td>Transportation</td>
<td>$0 co-pay; 24 one-way trips per year to or from approved locations</td>
<td>No coverage</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>Learn how to help reduce falls, prevent injuries and improve your balance and strength</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

*Benefits combined in and out-of-network

Plans are 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. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year. This information is not a complete description of benefits. Contact the plan for more information. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party. Limitations, co-payments, and restrictions may apply.
Benefits and services beyond

ORIGINAL MEDICARE

Get all the benefits of Original Medicare – and more.

With this plan, you get additional benefits and services designed to help you live a healthier life — most at little or no additional cost. More benefits mean more value. It also means more peace of mind for you, knowing you have access to a full range of services dedicated to your health and wellness.

Below are short descriptions about some of the 2017 plan benefits and services. Limitations, exclusions and restrictions may apply. For more detailed information, please see your Summary of Benefits.

**Vision coverage**

Protect your eyesight and health with routine eye exams. Your vision coverage may include:

- One routine eye exam every year
- Credit toward contact lenses or eyeglasses

Co-pays and network restrictions may apply.

**Dental coverage**

Getting routine preventive dental care can help protect your teeth and gums. The plan’s dental services may include exams, cleanings or X-rays. Co-pays and network restrictions may apply.

**Hearing coverage**

Don’t let hearing loss affect your life. Your plan includes the following hearing coverage:

- A routine hearing exam every year
- Hearing aids provided by the hi HealthInnovations™ mail order program

Co-pays and network restrictions may apply.
Benefits and services beyond
ORIGINAL MEDICARE

Transportation
Get rides to and from plan-approved locations, like your doctor’s office. See your Summary of Benefits for the specific number of one-way or round trips included with this plan.

Learn more about these extra services and benefits.
For more information, call 1-866-774-9671, TTY 711 8 a.m. to 8 p.m. local time, 7 days a week.
2017 Summary of BENEFITS

Erickson Advantage® Signature without Drugs (HMO-POS)

H5652-002

Our service area includes the following counties in:

- **Colorado**: Douglas;
- **Kansas**: Johnson;
- **Maryland**: Baltimore, Montgomery, Prince George's;
- **Massachusetts**: Essex, Plymouth;
- **Michigan**: Oakland;
- **New Jersey**: Monmouth, Morris;
- **Pennsylvania**: Bucks, Delaware;
- **Texas**: Collin, Harris;
- **Virginia**: Fairfax.

This is a summary of health services provided by Erickson Advantage® Signature without Drugs (HMO-POS) January 1st, 2017 - December 31st, 2017.

For more information, please contact Customer Service at:

**Toll-Free 1-866-774-9671, TTY 711**

8 a.m. - 8 p.m. local time, 7 days a week

[www.EricksonAdvantage.com](http://www.EricksonAdvantage.com)
Summary of Benefits

January 1st, 2017 - December 31st, 2017

We’re dedicated to providing clear and simple information about your plan so you always stay fully informed. The following information is a breakdown of what we cover and what you pay. This is called “cost-sharing” or “out-of-pocket” costs. Cost-sharing includes co-pays, co-insurance and deductibles. This will help you control your health care costs throughout the plan year.

Keep in mind that this isn’t a full list of benefits we provide, it’s just an overview. To get a complete list, visit our website at www.EricksonAdvantage.com to see the “Evidence of Coverage” or call customer service with any questions.

About this plan.

Erickson Advantage® Signature without Drugs (HMO-POS) is a Medicare Advantage HMOPOS plan with a Medicare contract.

To join Erickson Advantage® Signature without Drugs (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed on the cover, and be a United States citizen or lawfully present in the United States.

What’s inside?

Plan Premiums, Annual Deductibles, and Benefits

See plan costs including the monthly plan premium, deductible and maximum out-of-pocket limit.

Erickson Advantage® Signature without Drugs (HMO-POS) has a network of doctors, hospitals, and other providers. For some services you can use providers that are not in our network.

You can search for a network provider in the online directory at www.EricksonAdvantage.com.
# Erickson Advantage® Signature without Drugs (HMO-POS)

<table>
<thead>
<tr>
<th>Premiums and Benefits</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Plan Premium</td>
<td>$138</td>
<td></td>
</tr>
<tr>
<td>Annual Medical Deductible</td>
<td>This plan does not have a deductible.</td>
<td></td>
</tr>
<tr>
<td>Maximum Out-of-Pocket Amount</td>
<td>$5,000 annually for services you receive from in-network providers.</td>
<td>Unlimited Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>In-Network</td>
<td>Out-of-Network</td>
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<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td><strong>Inpatient Hospital Coverage</strong></td>
<td>$0 co-pay per day</td>
<td>30% of the cost per admit</td>
</tr>
<tr>
<td></td>
<td>Our plan covers an unlimited number of days for an inpatient hospital stay.</td>
<td></td>
</tr>
<tr>
<td><strong>Doctor Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>$0 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Specialists</td>
<td>$35 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare-covered</td>
<td>$0 co-pay</td>
<td>$0 co-pay - 30% of the cost</td>
</tr>
<tr>
<td>Routine physical</td>
<td>$0 co-pay; 1 per year*</td>
<td>30% of the cost; 1 per year*</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>$50 co-pay (worldwide) per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital co-pay instead of the Emergency co-pay. See the “Inpatient Hospital Care” section of this booklet for other costs.</td>
<td></td>
</tr>
<tr>
<td><strong>Urgently Needed Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30 co-pay</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Tests, Lab and Radiology Services, and X-Rays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic radiology services (e.g. MRI)</td>
<td>$50 co-pay per service</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Lab services</td>
<td>$0 co-pay</td>
<td>$0 co-pay</td>
</tr>
<tr>
<td>Diagnostic tests and procedures</td>
<td>$0 co-pay per service</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Therapeutic Radiology</td>
<td>$30 co-pay per service</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Outpatient X-rays</td>
<td>$20 co-pay per service</td>
<td>30% of the cost</td>
</tr>
<tr>
<td>Benefits</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Hearing Services</td>
<td><strong>Exam to diagnose and treat hearing and balance issues</strong></td>
<td><strong>$20 co-pay</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Routine hearing exam</strong></td>
<td><strong>$20 co-pay; 1 per year</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Hearing aid</strong></td>
<td><strong>$330-$380 co-pay for each HealthInnovations™ hearing aid, up to 2 per year (Additional fees with Power Max model)</strong></td>
</tr>
<tr>
<td>Dental Services</td>
<td><strong>Preventive</strong></td>
<td><strong>$35 co-pay for office visit (includes exam, cleaning, x-rays)</strong></td>
</tr>
<tr>
<td>Vision Services</td>
<td><strong>Exam to diagnose and treat diseases and conditions of the eye</strong></td>
<td><strong>$35 co-pay</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Eyewear after cataract surgery</strong></td>
<td><strong>$0 co-pay</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Routine eye exam</strong></td>
<td><strong>$35 co-pay</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Up to 1 every year</strong></td>
<td><strong>Up to 1 every year</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Eyewear</strong></td>
<td><strong>$0 co-pay every 2 years; up to $100 for lenses/ frames and contacts</strong></td>
</tr>
<tr>
<td>Benefits</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Mental Health Care</strong></td>
<td>Inpatient visit $0 co-pay per day: for days 1-90</td>
<td>30% of the cost per admit</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient group therapy visit</strong> $30 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient individual therapy visit</strong> $30 co-pay - $30 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility (SNF)</strong></td>
<td>$0 co-pay per day: for days 1-20 $75 co-pay per day: for days 21-87 $0 co-pay per day: for days 88-100</td>
<td>30% of the cost per admit, up to 100 days</td>
</tr>
<tr>
<td></td>
<td><strong>Our plan covers up to 100 days in a SNF.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
<td>Occupational therapy visit $0 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td></td>
<td><strong>Physical therapy and speech and language therapy visit</strong> $0 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>$150 co-pay</td>
<td>$150 co-pay</td>
</tr>
<tr>
<td><strong>Routine Transportation</strong></td>
<td>$0 co-pay; 24 one-way trips per year to or from approved locations</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Foot Care</strong> (podiatry services)</td>
<td>Foot exams and treatment $0 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td></td>
<td><strong>Routine foot care</strong> $0 co-pay; for each visit up to 6 visits every year*</td>
<td>30% of the cost; for each visit up to 6 visits every year*</td>
</tr>
<tr>
<td>Benefits</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Medical Equipment / Supplies</strong></td>
<td>Durable Medical Equipment (e.g., wheelchairs, oxygen)</td>
<td>20% of the cost</td>
</tr>
<tr>
<td></td>
<td>Prosthetics (e.g., braces, artificial limbs)</td>
<td>20% of the cost</td>
</tr>
<tr>
<td><strong>Wellness Programs</strong></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Part B Drugs</strong></td>
<td>Chemotherapy drugs</td>
<td>10% of the cost</td>
</tr>
<tr>
<td></td>
<td>Other Part B drugs</td>
<td>10% of the cost</td>
</tr>
</tbody>
</table>
## Additional Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>Manual manipulation of the spine to correct subluxation</td>
<td>$20 co-pay</td>
</tr>
<tr>
<td><strong>Diabetes Management</strong></td>
<td>Diabetes monitoring supplies</td>
<td>20% of the cost</td>
</tr>
<tr>
<td></td>
<td>Diabetes Self-management training</td>
<td>$0 co-pay</td>
</tr>
<tr>
<td></td>
<td>Therapeutic shoes or inserts</td>
<td>20% of the cost</td>
</tr>
<tr>
<td><strong>Falls Prevention</strong></td>
<td>Learn how to help reduce falls, prevent injuries and improve your balance and strength</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>$0 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>$50 co-pay</td>
<td>30% of the cost</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse</strong></td>
<td>Outpatient group therapy visit</td>
<td>$30 co-pay</td>
</tr>
<tr>
<td></td>
<td>Outpatient individual therapy visit</td>
<td>$30 co-pay</td>
</tr>
<tr>
<td><strong>Renal Dialysis</strong></td>
<td>20% of the cost</td>
<td>20% of the cost</td>
</tr>
</tbody>
</table>

*Benefits are combined in and out-of-network*
This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply.

The provider network may change at any time. You will receive notice when necessary.

Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

Plans are 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.

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 http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-866-774-9671.

This information is available for free in other languages. Please call our customer service number at 1-866-774-9671, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-866-774-9671, TTY 711, 8 a.m. a 8 p.m. hora local, los 7 días de la semana.
Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-866-774-9671. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-866-774-9671. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-866-774-9671。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-866-774-9671。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。


French: Nous proposons des services gratuits d’interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d’assurance-médicaments. Pour accéder au service d’interprétation, il vous suffit de nous appeler au 1-866-774-9671. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.


Korean: 담사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-774-9671번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-866-774-9671. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.
Arabic: 
إنهنا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-667-477-66771. سيفهم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की धारणा के बारे में आपके कस्तों भी पूछतां के लिए हमारे पास मुफ्त दुसाभाषी सेवाएं उपलब्ध हैं. एक दुसाभाषी पूछतां करने के लिए, बस हमें 1-866-774-9671 पर फोन करें. कोई व्यक्ति जो हिंदी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-866-774-9671. Un nostro incaricato che parla Italiano fornirà l’assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-866-774-9671. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sévis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-866-774-9671. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-866-774-9671. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-866-774-9671 にお電話ください。日本語を話す人者が支援いたします。これ無料のサービスです。
2016 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan’s quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan’s performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan’s scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for the ratings include:

- How our members rate our plan’s services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications

For 2016, Erickson Advantage received the following Overall Star Rating from Medicare:

★★★★★
5 stars

We received the following Summary Star Rating for Erickson Advantage’s health/drug plan services:

Health Plan Services: ★★★★
4.5 stars

Drug Plan Services: ★★★★★
5 stars

The number of stars shows how well our plan performs.

★★★★★ excellent
★★★★ above average
★★★ average
★★ below average
★ poor

Learn more about our plan and how we are different from other plans at www.medicare.gov. You may also contact us 8 a.m. - 8 p.m. local time, 7 days a week at 866-774-9671 (toll-free) or 711 (TTY).

Current members please call 866-314-8188 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

This plan got Medicare's highest rating (5 stars)
Plans are 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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply.

Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

The provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

Medicare evaluates plans based on a 5-Star rating system. Star Ratings are calculated each year and may change from one year to the next.

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

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

Your Plan may contain one or more of the following:

**Your Plan may contain one or more of the following:**

**NurseLine℠**
This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The service is not an insurance program and may be discontinued at any time.

**SilverSneakers®**
Consult a health care professional before beginning any exercise program. Availability of the SilverSneakers program varies by plan/market. Refer to your Evidence of Coverage for more details. Healthways and SilverSneakers are registered trademarks of Healthways, Inc. and/or its subsidiaries. © 2016 Healthways, Inc. All rights reserved.
Non-Discrimination Notice
UnitedHealthcare Insurance Company, on behalf of itself and its affiliated companies, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

UnitedHealthcare:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If you need these services, please call the Customer Service number at the front of this booklet, TTY 711.

If you believe that UnitedHealthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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

You can file a grievance by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the Customer Service number at the front of this booklet.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número de Servicio al Cliente que se encuentra en la portada de esta guía.

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請撥打本手冊封面的客戶服務部門電話號碼。

Tiếng Việt (Vietnamese)
CHỦ Y Nghề bạn nói Tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Vui lòng gọi số điện thoại của bạn Dịch vụ Hội viên ghi phía trước tập sách này.

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Pakitawagan ang numero ng Customer Service na nasa harap ng booklet na ito.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по номеру телефона Отдела по работе с клиентами, указанному на лицевой стороне данной брошюры.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero del Servizio alla clientela indicato all'inizio di questo libretto.

Deutsch (German)

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。本冊子の表紙に記載されているカスタマーサービスの電話番号にお電話ください。

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. لطفا با شماره تلفن خدمات اعضا بر روی جلد این کتابچه تواصل مگرید.

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कृपया इस पुस्तिका के आवरण पर दिए गए ग्राहक सेवा नंबर पर कॉल करें।

Հայերեն (Armenian)
Իսպանակաների համար բոլորին իր հայկազեր, քանի դեռ անբավարար դերը են բազմազանության
նորմատիվային աղբյուրերի համար։ Միջնորդություն է գնումների Հայաստանի
ազգայինակների համար։ Դա գնումներ է այն բազմության մասին։

ગુજરાતી (Gujarati)
સંપાદન: જે તમે ગુજરાતી બોલતા હો, તે નિશ્ચત ભાષા સહાય સેવાઓને તમારી માત્ર ઉપલબ્ધ છે. મહિરધાની કરી આ પુસ્તિકાના આગેના બાબતમાં આપેલ કિસ્તમર સર્વિસ નંબર ઉપર કોલ કરો.

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Thov hu rau Chaw Pab Qhua tus xov tooj ntawm nplooj npog phau ntawv no.

اردو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب بھی۔ برائے کرم اس کتابچے کے بیلے صفحہ پر موجود گلاب سروس نمبر پرکال کریں。

ខ្មែរ (Cambodian)
ការចែក: ប្រាប់ការចែករឹង និង ការចែករឹងក្នុង ដែលក្នុងការជួបទាន់ ប្រកួតប្រជុំខ្មែរ និងមិត្តបត្តិគ្រឹះស្រអាណ។
Punjabi)

बिभाजक दिन: ने नूरम भाना चेतृटे दें, उं डा का हिंद मातिका में ज्योत्त रहियाँ ज्योत्त धरियाँ रहियाँ। विज्ञान बदले दिन पुष्पवान दे गाथे रिम हिंद हिंद गाथे साधन 'उ' वां बढ़ अगर

Bengali)

নক্ষ করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে বিশ্বভাবে ভাষা সমাধান পরিবেশ উপলব্ধ আছে।

অনুসরণ করে এই পুস্তিকার সামনে দেওয়া গ্রাহক সেবা বা কাউন্সিল সার্ভিস লিপ্তর করুন করুন।

(Yiddish)

אינמצאוה: ראו ב ארא ראנה ראדה, גון פאראקרא פאר ארא פארא קרקה טוראפר טופר פרי מון אפקל. ביטא רופף

Amharic)


(Thai)

เรียน: ถ้าคุณพบปัญหาเกี่ยวกับข้อมูลหลักเกี่ยวกับภาษาได้ที่ โปรดโทรศัพท์ที่หมายเลขสัมภาษณ์บริการลูกค้า

Oromo (Oromo)

XIYYEFFANNA: Afaan dubbattu Oroomiffa, tajajila gargaarsa afaanii, kanfaltiidaan ala, ni argama. Maaloo fuula barruulee kana irraa karaa lakkoofsa bilbilaa Tajajijla Maamiltootaatiin bilbili.

Ilocano (Ilocano)

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenay. Maidawat nga awagan iti numero ti Customer Service ayan iti sango na daytoy nga booklet.

Lao)

ໂປພາວ (Lao)

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
Nepali (Nepali)

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten.

Kajin Majöl (Marshallese)

Gagana fa’a Sāmoa (Samoan)

Română (Romanian)

ATENŢIE: Dacă vorbiţi limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Vă rugăm să sunați la numărul Serviciului Clienţii de pe partea din faţă a acestei broşuri.

Foosun Chuuk (Trukese)


Tonga (Tongan)

FAKATOKANGA’I: Kapau ‘oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta’etotongi, pea teke lava ‘o ma’u ia. Kaki ko tā ki he fika ae vaha kihe kau kasitomaa ‘oku tuku atu ihe tohi ni.

Bisaya (Bisayan)

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Palihog kog tawag sa customer service nga numero sa atubangan aning booklet.

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Wohamagara ku numero y’ubudandaji iri imbere kuri kano gatabo.

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Tafadhali piga nambari ya Huduma kwa Wateja iliyoko mbele ya kijitabu hiki.
Deitsch (Pennsylvania Dutch)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf die Kunne Dinschte Nummer vanne in des Buchli.

ho’okomo ʻōlelo (Hawaiian)
E NĀNĀ MAI: Inā ho’opuka ‘oe i ka ʻōlelo [ho’okomo ʻōlelo], loa’a ke kōkua manuahi iā ‘oe. E ʻolu’olu ‘oe e kāhea ia ka helu kelepona ʻo Kōkua (Customer Service) ma mua o kēia pepelu.

Adamawa (Fulfulde)
MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ek kitaaki wolde caahu. Kusu noddu limngal hakkilanki Waroobe gonngal yeeso deftel nge’el.

tsalagi gawonihisdi (Cherokee)
Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Hwaclinohvl undalsdedi hia disesdi tsidegovhwela agyvididla gohwelli’i

I linguahén Chamoru (Chamorro)
ATENSIÓN: Yanggen un tungó [I linguahén Chamoru], i setbision linguahé gaige para hagu dibatde ha . Pot fabot agang i numerun Setbision Taotao gi me’nante na leblo.

Assyrian

(Burmese)

Diné Bizaad (Navajo)
Dii baa akó niníčin: Dii saad bee yánííłí’go Diné Bizaad, saad bee áká’ánida’áwo’déeq, t’áá jíik ’eh, eí ná hóló, T’áá shqóq dii nínaaltsoos wólta’i bidáahgi Na’íilniíhí Biká’ana’áwo’i bich’i’ béésh bee hane’i biká’ígíí bee hólne’ dooleel.

Bàsso-wúdú-po-nyá (Bassa)
Dè ðë nià ke dyédé gbo: Ȼ jú ke m [Bàsso-wúdú-po-nyá] jú ni, níi, à wudu kà kò ɗó po-poò bëin m gbo kpáa. Soho, sèbél i nsinga i homa bolo i nyuu mbon nlong i yé ntilga bissu bi kat yon.

Chahta (Choctaw)
ANOMPA PA PISAH: [Chahta] makilla ish anompoli hokma_ kvna hosh Nahollo Anompa ya pipilla hosh chj tosholahanla. Holisso tikba ɨlvppa itatoba toksvli ya ish ɨ paya chike.
When are the Medicare enrollment periods?

**Medicare Initial Enrollment Period**
Your Initial Enrollment Period (IEP) is when you first sign up for Medicare. Your IEP is seven months long. If you miss your IEP, you must wait to enroll in a Part C or Part D plan during Open Enrollment (October 15 – December 7), unless you qualify for an exception.

**Medicare Open Enrollment Period**
Medicare Open Enrollment is your chance to make changes to your coverage.

**Medicare Special Enrollment Period**
A Medicare Special Enrollment Period (SEP) allows you to enroll in Medicare or change your Medicare coverage outside of standard enrollment periods without paying a penalty. There are different SEPs to cover different life events.

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**Medicare Made Clear™ brought to you by UnitedHealthcare®**
Ways to ENROLL

Simply choose how you want to enroll in this plan from the options below. It doesn’t have to be complicated, pick the way that is easiest for you.

**BY PHONE**
Contact one of our Licensed Sales Representatives at 1-866-774-9671, (TTY 711) during 8 a.m. - 8 p.m. local time, 7 days a week to enroll over the phone or to schedule an individual appointment.

**AT A NEIGHBORHOOD MEETING**
Go to [www.EricksonAdvantage.com](http://www.EricksonAdvantage.com) to find a Neighborhood Meeting located near you.

**ONLINE**
Go to [www.EricksonAdvantage.com](http://www.EricksonAdvantage.com) and follow the step-by-step instructions to enroll.

**BY MAIL OR FAX**
Complete, sign and date the enrollment request form and send or fax to below:
UnitedHealthcare Medicare Enrollment Attn: Xerox/ACS
3315 Central AVE
Hot Springs, AR 71913
FAX 1-501-262-7070

Don’t forget to choose a primary care provider.

When you’re filling out your application, make sure to add the name, phone number and provider/PCP ID number of your primary care provider (PCP). Your PCP plays an important role in your health care needs. If you don’t have a PCP yet, a licensed sales representative can help you select one. You can also learn more online at [www.EricksonAdvantage.com](http://www.EricksonAdvantage.com).

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan’s contract renewal with Medicare.
Scope of Appointment Confirmation Form

Medicare requires Licensed Sales Representatives to document the scope of an appointment prior to any sales meeting to ensure understanding of what will be discussed between them and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential. A separate form should be completed for each Medicare beneficiary.

To ensure your appointment focuses only on those Medicare and health-related products you want to discuss with your licensed sales representative, please indicate by checking the appropriate box(es) beside the product(s) in which you are interested.

- [ ] Stand-alone Medicare Prescription Drug Plans (Part D)
- [ ] Medicare Advantage Plans (Part C) and Cost Plans
- [ ] Dental/Vision/Hearing Products
- [ ] Hospital Indemnity Products
- [ ] Medicare Supplement or (Medigap) Products

By signing this form, you agree to a meeting with a Licensed Sales Representative to discuss the types of products you checked above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment, or enroll you in a Medicare plan.

**Beneficiary or Authorized Representative Signature and Signature Date:**

<table>
<thead>
<tr>
<th>Signature</th>
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If you are the authorized representative, please sign above and print clearly and legibly below:

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<th>Name (First_Last)</th>
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**To be completed by Licensed Sales Representative** (please print clearly and legibly)

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<tr>
<th>Licensed Sales Representative Name (First_Last)</th>
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Scope of appointment (SOA) is subject to Medicare Record Retention Requirements

**Licensed Sales Representative:** If applicable, please explain why SOA was not documented and signed by beneficiary prior to meeting. Check all that apply.

- [ ] Unplanned Attendee
- [ ] New SOA required (consumer requested other Health Product information)
- [ ] Walk-in
- [ ] Other (please explain):

Fax to: 1-866-994-9659
Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone 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.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — 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) Plans — 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 copayment 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.

Other Related Products

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 co-pays/co-insurance. These plans are not affiliated or connected to Medicare.

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

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Y0066_160703_031612 Accepted   UHEX17MP3881978_000
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☐ Stand-alone Medicare Prescription Drug Plans (Part D) ☐ Hospital Indemnity Products
☐ Medicare Advantage Plans (Part C) and Cost Plans ☐ Medicare Supplement or (Medigap) Products
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Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan’s contract renewal with Medicare.

Y0066_160703_031612 Accepted UHEX17MP3881978_000
2017 Enrollment Request Form
Please contact the Plan if you need this information in another language or format (Braille).

☐ Erickson Advantage Signature without Drugs (HMO-POS) H5652-002 - ES

This plan is for people who live in a skilled nursing home on an Erickson campus.
This is a Health Maintenance Organization - Point of Service (HMO-POS) plan. It has a network of
doctors, specialists, hospitals and other providers you can use. In some cases, you may get
covered services from out-of-network providers. However, if you go to a provider within the
network, the costs may be lower.

Information about you.
Please type or print in black or blue ink.

☐ Mr. ☐ Mrs. ☐ Ms.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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<tr>
<th>Birth Date</th>
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<td>MM/DD/YYYY</td>
<td>☐ Male ☐ Female</td>
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Permanent Residence Street Address (P.O. BOX IS NOT ALLOWED)

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
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</table>

Mailing Address (Only if it’s different from your permanent residence street address. You can give
a P.O. box.)

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<thead>
<tr>
<th>City</th>
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<th>ZIP Code</th>
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Email Address:

Enrollee Name
Y0066_160609_110539 Approved  EREX17PO3876159_000
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Information about your Medicare.

Please use the information from your red, white and blue Medicare card. Remember, you need to have both Medicare Part A and Part B to join this plan.

You can simply fill in the blanks so they match your card.

Or attach a copy of the card or your letter from Social Security or the Railroad Retirement Board.

How do you want to pay?

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

This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we’ll add it to your premium.

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

☐ I want to pay directly from my bank account.

- Please attach a blank check from the account you’d like to use. Write “VOID” across the front. Please DO NOT send a deposit slip or money order.
- Please read the statement below.

My bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). My bank will pay the funds from my checking or savings account on or about the fifth of each month.

If I choose to stop paying directly from my account, I will tell both UHIC and my bank. I will give them a reasonable amount of time to change my method of payment.

Account Type ☐ Checking ☐ Savings

Account Holder Name ________________________________

Bank Routing Number ________________________________

Bank Account Number ________________________________

Sign Here ________________________________ Date Signed __________________

☐ I want to pay from my Social Security or Railroad Retirement Board (RRB) check.

We’ll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request
for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ I want to pay by mail.

We’ll send a bill to your mailing address each month.

---

**A few notes about your costs.**

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

Please DO NOT pay the plan the Part D-IRMAA at this time.

**Need help with your prescription drug costs?**

If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, you won’t have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don’t even know it. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn’t cover.

For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

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**A few questions to help us manage your plan.**

1. Would you prefer plan information in another language or format?  ☐ Yes ☐ No

   Please check what you’d like:  ☐ Spanish ☐ Other________________

If you don’t see the language or format you want, please call us at 1-866-774-9671, TTY 711 during 8 a.m. - 8 p.m. local time, 7 days a week. Or visit www.EricksonAdvantage.com for online help.
2. Do you have end stage renal disease? □ Yes □ No

If you have had a successful kidney transplant and/or you don’t need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.

If “yes,” are you currently a member of a health care company? □ Yes □ No

Name of Company ________________________________

Member ID ________________________________

3. Are you enrolled in your State Medicaid program? □ Yes □ No

If yes, please give us your Medicaid number: ____________

4. Do you live in a nursing home or a long-term care facility? □ Yes □ No

If yes, please give us information on the long-term care facility:

Name ________________________________

Address ________________________________

City __________________________ State _______ ZIP Code ________

Phone Number ( ___ ) ___-_____ Date You Moved There ___/___/_____ ___/___/_____

5. Do you have health insurance with an employer or union right now? □ Yes □ No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union’s website, or read any information sent to you. If there is no any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

6. 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, Workman’s Compensation, Auto Liability, or Veterans benefits) □ Yes □ No

If yes, please complete the following:

Name of Health Insurance Company ________________________________

Subscriber Name ___________________________ Group ID ________________________________

Member ID ___________________________ Effective Dates (if applicable) ___/___/_____ - ___/___/_____

Enrollee Name Y0066_160609_110539 Approved EREX17PO3876159_000
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7. 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 current Provider Directory.

<table>
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<tr>
<th>Provider or PCP Full Name</th>
<th>Phone Number ( ) -</th>
</tr>
</thead>
</table>

Provider/PCP ID Number: [ ]
(Please enter the number exactly as it appears on the website or in the current Provider Directory. It will be 10 to 12 digits. Don't include dashes.)

Are you now seeing or have you recently seen this doctor? □ Yes □ No

Please read and sign.

By completing this form, I agree to the following:

- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I may have to pay a late enrollment penalty (LEP). This would only happen if I didn’t sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. “Creditable” means the coverage is as good as a Medicare prescription drug plan. If I need to pay a LEP, the plan will tell me.
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- I understand that beginning on the date the plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the plan provides refunds for all covered benefits, even if I get services out of network.
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• If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I’ve been accepted into the plan.
• My plan will give my information to Medicare and other plans when needed for treatment, payment and health care operations. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
• If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
• The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose 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 that I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

Signature of Applicant/Member/Authorized Representative:

Today's Date  M M / D D / Y Y Y Y

If you are the authorized representative, please sign above and complete the information below.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number ( )</th>
<th>Relationship to Applicant</th>
</tr>
</thead>
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<tr>
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</tbody>
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Enrollee Name  
Y0066_160609_110539 Approved  
EREX17PO3876159_000
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<tr>
<th>New Member</th>
<th>Plan Change</th>
<th>Employer Group Name</th>
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Where did this application originate?

- [ ] Retail/Mall Program
- [ ] Local Event Outreach
- [ ] Local B2B Outreach
- [ ] Member Meeting
- [ ] Community Meeting
- [ ] Other

How was this application submitted?

- [ ] Appointment
- [ ] Other
- [ ] Mail In

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<th>Proposed Effective Date</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>MM/DD/YYYY</td>
</tr>
</tbody>
</table>

Licensed Sales Representative Phone Number ( ) –

**Agent must complete**

- [ ] AEP
- [ ] SEP (Chronic)
- [ ] IEP (MA-PD enrollees eligible for 2nd IEP)
- [ ] OEP
- [ ] IEP (MA-PD enrollees)
- [ ] SEP (Partial Dual Eligible)
- [ ] ICEP (MA enrollees)
- [ ] SEP (Full Dual Eligible)
- [ ] SEP (SEP Reason) ____________________________
- [ ] SEP Eligibility Date MM/DD/YYYY

**Licensed Sales Representative Signature (required)**

---

Plans are insured through UnitedHealthcare® Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan’s contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number at 1-866-774-9671, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week.

Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro Servicio al Cliente al número 1-866-774-9671, TTY 711, de 8 a.m. a 8 p.m. hora local, los 7 días de la semana.

本資訊也有其他語言的免費版本。請撥打1-866-774-9671 聯絡我們的客戶服務部，聽力語言殘障服務專線711, 每週7 天，當地時間上午8 時至晚上 8 時。
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2017 Enrollment Request Form

Please contact the Plan if you need this information in another language or format (Braille).

☐ Erickson Advantage Signature without Drugs (HMO-POS) H5652-002 - ES

This plan is for people who live in a skilled nursing home on an Erickson campus.

This is a Health Maintenance Organization - Point of Service (HMO-POS) plan. It has a network of doctors, specialists, hospitals and other providers you can use. In some cases, you may get covered services from out-of-network providers. However, if you go to a provider within the network, the costs may be lower.

**Information about you.**

Please type or print in black or blue ink.

<table>
<thead>
<tr>
<th>☐ Mr.</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Mrs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Ms.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Birth Date  **M M / D D / Y Y Y Y**

Gender  ☐ Male  ☐ Female

Main Phone Number  (    )  -

Other Phone Number  (    )  -

Permanent Residence Street Address (P.O. BOX IS NOT ALLOWED)

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

Mailing Address (Only if it’s different from your permanent residence street address. You can give a P.O. box.)

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

Email Address:

---

Enrollee Name

Y0066_160609_110539 Approved  EREX17PO3876159_000

53
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Information about your Medicare.

Please use the information from your red, white and blue Medicare card. Remember, you need to have both Medicare Part A and Part B to join this plan.

You can simply fill in the blanks so they match your card.

Or attach a copy of the card or your letter from Social Security or the Railroad Retirement Board.

How do you want to pay?

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

This plan has a premium (monthly payment). Please choose how you want to pay it. Note: If you have a late enrollment penalty (LEP), we’ll add it to your premium.

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

☐ I want to pay directly from my bank account.

• Please attach a blank check from the account you’d like to use. Write “VOID” across the front. Please DO NOT send a deposit slip or money order.

• Please read the statement below.

My bank may pay my plan premium to UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York residents) (UHIC). My bank will pay the funds from my checking or savings account on or about the fifth of each month.

If I choose to stop paying directly from my account, I will tell both UHIC and my bank. I will give them a reasonable amount of time to change my method of payment.

Account Type □ Checking □ Savings

Account Holder Name  _____________________________

Bank Routing Number  _____________________________

Bank Account Number  _____________________________

Sign Here  _____________________________ Date Signed  _________________

☐ I want to pay from my Social Security or Railroad Retirement Board (RRB) check.

We’ll set it up. It may take a few months before payment starts, so the first payment may include more than one premium. In most cases, if Social Security or RRB accepts your request
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for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

☐ I want to pay by mail.
   We’ll send a bill to your mailing address each month.

A few notes about your costs.

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
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Please DO NOT pay the plan the Part D-IRMAA at this time.

Need help with your prescription drug costs?
If you have a limited income, you may be able to get Extra Help with your prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, you won’t have a coverage gap or late enrollment penalty. Many people are eligible for these savings and don’t even know it. If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only part of your premium, we will bill you for the amount that Medicare doesn’t cover.

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A few questions to help us manage your plan.

1. Would you prefer plan information in another language or format?  ☐ Yes  ☐ No
   Please check what you’d like:  ☐ Spanish  ☐ Other_______________

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2. Do you have end stage renal disease?  □ Yes  □ No

If you have had a successful kidney transplant and/or you don’t need regular dialysis anymore, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don’t need dialysis, otherwise we may need to contact you to obtain additional information.

If “yes,” are you currently a member of a health care company?  □ Yes  □ No

Name of Company ____________________________________________________________

Member ID ________________________________________________________________

3. Are you enrolled in your State Medicaid program?  □ Yes  □ No

If yes, please give us your Medicaid number: ________________________________

4. Do you live in a nursing home or a long-term care facility?  □ Yes  □ No

If yes, please give us information on the long-term care facility:

Name __________________________________________________________

Address ________________________________ City ____________________________ State ______ ZIP Code ______

Phone Number ( ) – Date You Moved There MM/DD/YYYY

5. Do you have health insurance with an employer or union right now?  □ Yes  □ No

If yes, you could lose that plan if you join this plan. Please talk to your employer or union. Ask how joining this plan could affect your current plan. You may also want to check your employer or union’s website, or read any information sent to you. If there is no any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

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Do you or your spouse have other health insurance that will cover medical services? (Examples: Other employer group coverage, LTD coverage, Workman’s Compensation, Auto Liability, or Veterans benefits)  □ Yes  □ No

If yes, please complete the following:

Name of Health Insurance Company __________________________________________

Subscriber Name ____________________________ Group ID __________________________

Member ID ____________________________ Effective Dates (if applicable) MM/DD/YYYY - MM/DD/YYYY

Enrollee Name

Y0066_160609_110539 Approved
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7. Please give us the name of your primary care provider (PCP), clinic or health center.
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Are you now seeing or have you recently seen this doctor? □ Yes □ No

Please read and sign.

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- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
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- I understand that beginning on the date the plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the plan provides refunds for all covered benefits, even if I get services out of network.

Enrollee Name
Y0066_160609_110539 Approved EREX17PO3876159_000
• If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I’ve been accepted into the plan.

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If I sign as an authorized representative, it means that I have the legal right under state law to sign. I can show written proof of this right if Medicare asks for it.

Signature of Applicant/Member/Authorized Representative:

Today’s Date  M M D D / Y Y Y Y

If you are the authorized representative, please sign above and complete the information below.

Last Name | First Name
--- | ---
Address
City | State | ZIP Code
Phone Number ( ) – | Relationship to Applicant
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| For licensed sales representative/agency use only. |
|---------------------------------------------------|-----------------|
| □ New Member                                      | Employer Group Name |
| □ Plan Change                                     |                 |

<table>
<thead>
<tr>
<th>Employer Group ID</th>
<th>Branch ID</th>
</tr>
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<tbody>
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</tbody>
</table>

Where did this application originate?

- □ Retail/Mall Program
- □ Local Event Outreach
- □ Local B2B Outreach
- □ Member Meeting
- □ Community Meeting
- □ Other

How was this application submitted?

- □ Appointment
- □ Other
- □ Mail In

<table>
<thead>
<tr>
<th>Licensed Sales Representative/Writing ID</th>
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Licensed Sales Representative Phone Number ( ) —

Agent must complete

- □ AEP
- □ SEP (Chronic)
- □ SEP (ERP MA-PD enrollees eligible for 2nd IEP)
- □ OEP
- □ IEP (MA-PD enrollees)
- □ SEP (Partial Dual Eligible)
- □ ICEP (MA enrollees)
- □ SEP (Full Dual Eligible)
- □ SEP (SEP Reason) —
- □ SEP Eligibility Date MM/DD/YYYY

Licensed Sales Representative Signature (required)

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This page intentionally left blank.
We want to help you fully understand your chosen plan and options.

Fill out this worksheet with your Licensed Sales Representative. It will walk you through all of the details to help you make sure this plan fits your needs.

**PLAN INFORMATION**  Here are some details about your plan and coverage.

<table>
<thead>
<tr>
<th>My new plan is (circle one):</th>
<th>Medicare Supplement Insurance (Medigap) plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare Advantage plan</td>
</tr>
<tr>
<td></td>
<td>Medicare Part D plan</td>
</tr>
</tbody>
</table>

The name of my new plan is: ____________________________

My plan coverage begins (effective date):  **M M / D D / Y Y Y Y**

My plan type is (circle):  HMO  HMO-POS  LPPO  RPPO  PFFS  

My plan type:  □ Requires referrals  □ Does not require referrals

I have purchased rider(s) as part of my plan:  □ Yes  □ No  □ N/A

I must have Medicare Part A and Part B to enroll in this plan.

My plan is available only in the plan’s service area, which is: ____________________________.

If I move outside of the service area for more than six months in a row, I will need to choose a new plan. I will ask my Licensed Sales Representative or Customer Service to help me.

My plan will now provide:  □ all my Medicare health coverage  

□ all my Medicare prescription drug coverage

**Circle the correct answer:**

I should / should not have a Medicare Advantage plan and a Medicare supplement insurance (Medigap) policy at the same time. If I have a Medicare supplement policy right now, once I receive confirmation of my enrollment in my new Medicare advantage plan, I will write to that insurance company, ____________________________, to cancel my Medicare supplement policy.

I should / should not have a Medicare Advantage plan and a stand-alone Medicare Part D plan at the same time. (There is one exception: Medicare Advantage Private Fee-for-Service plans that do not include prescription drug coverage.)

I can cancel my enrollment in this plan before my coverage starts by calling Customer Service at ____________________________. If my plan coverage starts and I want to leave the plan, I will need to wait until the Open Enrollment Period, unless I qualify for a Special Enrollment Period.
PREMIUM INFORMATION  What you need to know about paying a monthly premium.

I need to continue to pay my Medicare Part B premium unless the state or another third party pays this premium for me. My plan has a $__________ monthly premium. I must pay this monthly premium to stay in this plan.

If I owe a Late Enrollment Penalty (LEP), it is not included in my premium. I will need to add it to my premium each month.

NETWORK INFORMATION  Understanding your network is important.

My current primary care provider, __________________, is currently in the plan’s network.
My specialists, ________________, ________________, ________________, are currently in the plan’s network.

Circle the correct answers: If I get my care from out-of-network providers, I may pay less / more of the cost. I should call before my appointment to make sure the provider will accept my plan.

My Licensed Sales Representative is committed to helping me sign up for the plan that’s right for me and my health needs at the time of my enrollment.

I understand that this plan can change each year. This current plan is valid from ________________ to ________________. I can enroll in a different plan each year during the Open Enrollment Period.

If I have any questions about my plan or if my needs change, I can call my Licensed Sales Representative at: ________________. I can also call the Customer Service number on the front of this booklet.
PLAN INFORMATION  Here are some details about your plan and coverage.

My new plan is (circle one):  Medicare Supplement Insurance (Medigap) plan
Medicare Advantage plan       Medicare Part D plan

The name of my new plan is: ________________________________

My plan coverage begins (effective date): M M / D D / Y Y Y Y

My plan type is (circle):  HMO      HMO-POS      LPPO      RPPO      PFFS

My plan type:  ☐ Requires referrals  ☐ Does not require referrals

I have purchased rider(s) as part of my plan:  ☐ Yes  ☐ No  ☐ N/A

I must have Medicare Part A and Part B to enroll in this plan.

My plan is available only in the plan’s service area, which is: ________________________________.

If I move outside of the service area for more than six months in a row, I will need to choose a new plan. I will ask my Licensed Sales Representative or Customer Service to help me.

My plan will now provide:  ☐ all my Medicare health coverage
☐ all my Medicare prescription drug coverage

Circle the correct answer:

I should / should not have a Medicare Advantage plan and a Medicare supplement insurance (Medigap) policy at the same time. If I have a Medicare supplement policy right now, once I receive confirmation of my enrollment in my new Medicare advantage plan, I will write to that insurance company, ________________________________, to cancel my Medicare supplement policy.

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If I have any questions about my plan or if my needs change, I can call my Licensed Sales Representative at: __________________. I can also call the Customer Service number on the front of this booklet.
2017 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. You will receive a copy of your original Enrollment Request Form in the mail within two weeks. If you do not receive a copy, please contact your local Licensed Sales Representative. This receipt is not a guarantee of enrollment.

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

**Applicant 1:**

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<th>Name</th>
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<tr>
<th>Application Date</th>
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<tr>
<td>Proposed Effective Date</td>
<td>MM / DD / YYYY</td>
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<tr>
<td>Plan Name</td>
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<tr>
<td>Plan Type</td>
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<tr>
<td>Health Plan/PBP No.</td>
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<tr>
<td>Enrollment Tracking No. (if applicable)</td>
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**Applicant 2 (if applicable):**

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<th>Name</th>
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<th>Application Date</th>
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Call your local Licensed Sales Representative if you have any questions:

<table>
<thead>
<tr>
<th>Licensed Sales Representative Name</th>
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<tbody>
<tr>
<td>Licensed Sales Representative Phone No.</td>
</tr>
<tr>
<td>Licensed Sales Representative ID</td>
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</table>

We’re always here to help. Customer Service is happy to help with any questions or concerns you have.

Call them toll-free at 1-866-774-9671, 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, you may cancel by contacting the insurer.

Plans are insured through UnitedHealthcare® Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in these plans depends on the plan’s contract renewal with Medicare.

Y0066_160703_031205 Accepted

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WE’RE IN THIS TOGETHER.

When it comes to managing your health, you’re in the driver’s seat. But, we’re always here to help when you need it. We’ll also send you helpful information along the way.

Here’s what you can expect next.

- **Verification Letter**: We received your application.
- **Welcome Letter and Member ID Card**: Your application has been approved.
- **Getting Started Guide and Plan Details**: Learn to make the most of your plan.
- **Your Plan Coverage Begins**: You can start using your plan.

Get ready to get the most out of your plan.

- **Schedule your Annual Physical and Wellness Visit.**
  Make sure to schedule your appointments for after your coverage begins.
- **Complete a health assessment after your coverage begins.**
  Medicare requires the plan to send a health assessment to Medicare members. We’ll use your answers to suggest helpful programs and resources.

Thank you for choosing us.

Remember, we’re just a phone call away.

Toll-Free: 1-866-314-8188, TTY 711
8 a.m- 8 p.m. local time, 7 days a week

NOTES
Questions? We’re here to help.

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