Plan Recap

We want to make sure you know what to expect with the new plan you've chosen.
✔ Please fill out this plan recap with your Licensed Sales Representative (if applicable).

Plan Information

The name of my new plan is: _____

My new plan is a: ☐ Medicare Advantage plan ☐ Medicare Advantage Special Needs plan
☐ Medicare Part D plan ☐ Medicare Supplement Insurance (Medigap) plan

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

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

☐ Includes a medical deductible, unless the state or another third party pays it for me
☐ Does not include a medical deductible

My plan will provide: ☐ All Medicare health coverage ☐ All Medicare prescription drug coverage
I have purchased rider(s) as part of my plan: ☐ **Yes** ☐ **No** ☐ N/A

Proposed effective date: - -

I can cancel my enrollment in this plan before my coverage starts by calling Customer Service. Once my coverage starts, I may have to wait until I have a valid election period to make a plan change.

I must live in the plan's service area, which is _____. If I move out of the plan's service area for more than 6 months in a row, I will need to choose a new plan.

Circle the correct answer: I should / should not have a Medicare Advantage plan and a stand-alone Medicare Part D plan at the same time.
I have **opted / not opted** to access some plan documents electronically. I have **provided / not provided** my email address as another way for the plan to contact me with important information. I can update or change this anytime.

Premium Information

My plan has a $ _____ monthly premium that I must pay to stay in this plan. If I qualify for Extra Help, my premium may be less. I must remain enrolled in Medicare Part A and Part B and must continue to pay my Medicare Part B premium, unless it's paid by the state or a third party. If I owe a Late Enrollment Penalty (LEP), it is not included in my premium. I will need to pay the LEP in addition to my premium each month.

Select the payment method you will use to pay your monthly premium:

☐ Direct bill each month ☐ Deduction from my Railroad Retirement check
☐ Deduction from my Social Security check ☐ Automatic payment from my bank account

Deductions from your Social Security check may be denied by the Centers for Medicare & Medicaid Services (CMS). If approved, it may take a month or 2 for payments to begin. We'll send you a bill until your Social Security payment is accepted and set up.

Network Information

With my plan, I need to get my care and services from network providers. I may have to pay the full cost for any care I get from out-of-network providers. Emergency care, urgent care, and out-of-area dialysis is covered wherever I need it. ☐ **Yes** ☐ **No**

List the doctors and hospitals you use in this table. Be sure to note whether they are part of the provider network and if they require referrals.

Provider Name	**Provider Type** (PCP/Specialist/Hospital)	**Network** (Yes/No)	**Referral** (Yes/No)

Prescription Drug Coverage

My plan (circle one) **does not have a deductible / has a $ _____ deductible** that applies to drugs in (circle the tier(s)): **Tier 1 / Tier 2 / Tier 3 / Tier 4 / Tier 5 / ALL tiers**
List your medications and any applicable tier levels, drug limits or deductibles below:

Medication	**Tier Level**[1]	**Has Limits**[2] (Yes/No)	**Deductible** (Yes/No)

Contact your Licensed Sales Representative

If I have questions about my plan, I will call _____ at _____ or Customer Service at _____.

PREFERRED CARE NETWORK
A UnitedHealthcare Company

[1] My actual out of pocket costs may vary based on: the drug stage I am in, my drug tier level, the pharmacy I use (retail/mail-order), if I have Extra Help, and if my plan is participating in the Part D Senior Savings Model. [2] For medications that have limitations, I may need to contact the plan before I can fill my prescription. I can discuss alternatives by calling Customer Service to learn what other drugs might be on the Drug List and by talking with my doctor or pharmacist.