United Healthcare® Community Plan

SCO Senior Care Options Medicare Advantage

MassHealth

2025 MassHealth SCO Medicare Advantage Enrollment Request Form

☐ **UHC Senior Care Options MA-Y001 (HMO D-SNP) H2226-001-000**
☐ **UHC Senior Care Options NHC MA-Y002 (HMO D-SNP) H2226-003-000**

This form is for people who have MassHealth Standard (Medicaid) benefits and choose to enroll in UnitedHealthcare® Senior Care Options. You must also have Medicare Parts A and B.
If you have MassHealth Standard, but you do not qualify for Original Medicare, you may still be eligible to enroll in our MassHealth Senior Care Option plan and receive all of your MassHealth benefits through our UnitedHealthcare® SCO program.

MassHealth Standard (Medicaid) Information

Are you enrolled in MassHealth? ☐ Yes ☐ No

Please write your MassHealth number or attach a copy of your MassHealth card. Your MassHealth number is the 12-digit number under your name.

MassHealth Number _____

You must have MassHealth Standard benefits to enroll in a senior care organization. To apply for MassHealth, call 1-888-834-3721 (TTY 1-800-497-4648 for people with partial or total hearing loss).

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 ( ) —

☐ I give consent for UnitedHealthcare and its affiliates to call the phone number(s) I have provided using an autodialer and/or prerecorded voice technology.

Social Security number

(Required for people who are enrolling in D-SNP plans): __ __ __ - __ __ - __ __ __ __

Name of skilled nursing facility (if applicable)

_____

Enrollee name _____

Agent name/ID number _____

Medicare number

Permanent residence street address **(Don't enter a P.O. box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address)**

City	County	State	Zip code

Mailing address **(Only if it's different from above. You can give a P.O. box.)**

City	State	Zip code

Email address (optional)

Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No
(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)
If **yes**, what is it?

Name of other insurance

Member number	Group number	RxBin	RxPCN (optional)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

A few questions to help us manage your plan

1. Would you prefer plan information in another language or an accessible format?

If you would prefer plan information in another language or accessible format, please check what you'd like: ☐ Spanish ☐ Chinese ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD ☐ Other_____

If you don't see the language or format you want, please call us toll-free at **1-844-560-4944**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/CommunityPlan** for online help.

2. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

____ No, not of Hispanic, Latino/a, or Spanish origin
____ Yes, Mexican, Mexican American, or Chicano/a
____ Yes, Puerto Rican
____ Yes, Cuban
____ Yes, another Hispanic, Latino, or Spanish origin

Enrollee name _____
Agent name/ID number _____

____ **I choose not to answer**

3. What's your race? Select all that apply.

____ American Indian or Alaska Native

___ Black or African American

Asian:
____ Asian Indian
____ Chinese
____ Filipino
____ Japanese
____ Korean
____ Vietnamese
____ Other Asian

Native Hawaiian or Pacific Islander:
____ Guamanian or Chamorro
____ Native Hawaiian
____ Samoan
____ Other Pacific Islander

____ White
____ **I choose not to answer**

____ Member/Citizen of a federal or state recognized Tribe (name of Tribe) _____

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 health insurance company

Member number

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

You can find a list on the plan website or in the Provider Directory.

Provider or PCP full name	
Provider/PCP number	(Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.)

Are you now seeing or have you recently seen this provider? ☐ Yes ☐ No

Please read and sign

By completing this form, I agree to the following:

- This senior care organization, UnitedHealthcare® SCO, is a Medicare Advantage plan and has a contract with the federal government. UnitedHealthcare® SCO also has a contract with the

Enrollee name _____

Agent name/ID number _____

Commonwealth of Massachusetts/MassHealth. This is not a Medicare Supplement plan. I will need to keep my MassHealth Standard plan. 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.

- Because I have MassHealth, I may leave UnitedHealthcare® SCO if I have a qualifying election period. I will no longer be covered by UnitedHealthcare® SCO on the first day of the month following the month I request to leave UnitedHealthcare® SCO. UnitedHealthcare® SCO serves a specific service area. If I move out of the area that UnitedHealthcare® SCO serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of UnitedHealthcare® SCO, I have the right to appeal plan decisions about payment or services if I disagree with them.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border. This plan covers emergency and urgent care outside of the U.S. See the Summary of Benefits for more information.
- I understand that when my UnitedHealthcare coverage begins, I must get all of my medical and prescription drug benefits from UnitedHealthcare. Benefits and services authorized by UnitedHealthcare and contained in my UnitedHealthcare "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor UnitedHealthcare will pay for benefits or services that are not covered.
- 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.
- Joining this plan could affect my employer or union health benefits. If I have health coverage from an employer or union, joining this plan may change how my current coverage works. Me or my dependents could lose our other health or drug coverage completely and not get it back if I join this plan. I will talk to my employer or union. I will ask how joining this plan could affect my current plan. I may also want to check my employer or union's website, or read any information sent to me. If there is no information on whom to contact, my benefits administrator or the office that answers questions about my coverage can help.
- **Estate Recovery Awareness:** MassHealth is required by federal law to recover money from the estates of certain MassHealth members who are age 55 years or older, and who are any age

and are receiving long-term care in a nursing home or other medical institution. For more information about MassHealth estate recovery, please visit www.mass.gov/estaterecovery

☐ 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.

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

Enrollee name _____

Agent name/ID number _____

Licensed Sales representative/agent name	Proposed effective date

Agent must complete

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

☐ SEP (SEP reason) _____

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

Please mail or fax this completed form to:

UnitedHealthcare
1325 Boylston Street, 11th Floor
Boston, MA 02215

Fax: 1-855-250-2168
Fax the front and back of each page

Enrollee name _____
Agent name/ID number _____

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

UHC Senior Care Options MA-Y001 (HMO D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare.

UnitedHealthcare Senior Care Options is a Coordinated Care plan with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in the plan depends on the plan's contract renewal with Medicare. This plan is a voluntary program that is available to anyone 65 and older who qualifies for MassHealth Standard and Original Medicare and does not have any other comprehensive health insurance, except Medicare. If you have MassHealth Standard, but you do not qualify for Original Medicare, you may still be eligible to enroll in our MassHealth Senior Care Option plan and receive all of your MassHealth benefits through our Senior Care Options program. UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-844-560-4944 TTY **711**, daily, 8:00 a.m. to 8:00 p.m.

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

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

OMB No. 0938-1378
Expires: 6/30/2026

Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits

- ✔ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit our plan website or call to view a copy of the EOC. Our phone number and website are listed on the back cover of this book.
- ✔ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ✔ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ✔ Review the Formulary to make sure your drugs are covered.

Understanding important rules

- ✔ Benefits, premiums and/or copays/coinsurance may change on January 1 of each year.
- ✔ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ✔ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ✔ This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. To qualify, you must be 65 or older, be eligible to receive Medicare Part A, and be enrolled in Medicare Part B and MassHealth Standard. You may also need to live in your own home or a nursing facility. If you have MassHealth Standard, but you do not qualify for Medicare Part A and/or Medicare Part B, you may still be eligible to enroll.