



# Summary of Benefits 2025

**UHC Complete Care Support AM-1A (Regional PPO C-SNP)**

R3444-008-000

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



**[UHC.com/Medicare](https://UHC.com/Medicare)**



**Toll-free 1-866-367-7527, TTY 711**

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

**United  
Healthcare®**

# Summary of Benefits

**January 1, 2025 - December 31, 2025**

This is a summary of what we cover and what you pay. For a complete list of covered services, limitations and exclusions, review the Evidence of Coverage (EOC) at [MyUHC Medicare.com](https://www.myuhcmedicare.com) or call Customer Service for help. After you enroll in the plan, you will get more information on how to view your plan details online.

## UHC Complete Care Support AM-1A (Regional PPO C-SNP)

Medical premium, deductible and limits		
	In-network	Out-of-network
<b>Monthly plan premium</b>	\$25.60	
<b>Annual medical deductible</b>	You pay the Original Medicare Part B deductible amount combined in and out-of-network for 2025 which will be set by CMS in the fall of 2024. This is the 2024 deductible amount and may change for 2025. Our plan will provide updated rates as soon as they are released. The 2024 Medicare Deductible amount is \$240.	
<b>Maximum out-of-pocket amount</b> (does not include prescription drugs)	\$9,350  This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from any provider.  If you reach this amount, you will still need to pay your monthly premiums. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount.	
<b>Medicare cost-sharing</b>	If you have full Medicaid benefits or are a Qualified Medicare Beneficiary (QMB), you will pay \$0 for your Medicare-covered services as noted by the cost-sharing in this chart.	If you are a QMB or you have full Medicaid benefits and your provider accepts Medicaid, you will pay \$0 for your Medicare-covered services. Otherwise, you will pay the cost-sharing amount as noted in this chart.

Medical benefits			
		In-network	Out-of-network
<b>Inpatient hospital care<sup>2</sup></b> Our plan covers an unlimited number of days for an inpatient hospital stay.		Depending upon your level of Medicaid eligibility, you pay \$0 copay per stay, or; \$1,485 copay per stay	\$1,485 copay per stay
<b>Outpatient hospital</b> Cost-sharing for additional plan covered services will apply.	Ambulatory surgical center (ASC) <sup>2</sup>	\$0 copay for a colonoscopy Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance otherwise	\$0 copay for a colonoscopy 20% coinsurance otherwise
	Outpatient hospital, including surgery <sup>2</sup>	\$0 copay for a colonoscopy Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance otherwise	\$0 copay for a colonoscopy 20% coinsurance otherwise
	Outpatient hospital observation services <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
<b>Doctor visits</b>	Primary care provider	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Specialists <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Virtual medical visits	\$0 copay to talk with a network telehealth provider online through live audio and video	
<b>Preventive services</b>	Routine physical	\$0 copay, 1 per year*	\$0 copay, 1 per year*
	Medicare-covered	\$0 copay	\$0 copay
		<input type="checkbox"/> Abdominal aortic aneurysm screening <input type="checkbox"/> Alcohol misuse counseling	<input type="checkbox"/> Annual wellness visit <input type="checkbox"/> Bone mass measurement

## Medical benefits

	In-network	Out-of-network
	<ul style="list-style-type: none"><li><input type="checkbox"/> Breast cancer screening (mammogram)</li><li><input type="checkbox"/> Cardiovascular disease (behavioral therapy)</li><li><input type="checkbox"/> Cardiovascular screening</li><li><input type="checkbox"/> Cervical and vaginal cancer screening</li><li><input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li><li><input type="checkbox"/> Depression screening</li><li><input type="checkbox"/> Diabetes screenings and monitoring</li><li><input type="checkbox"/> Hepatitis C screening</li><li><input type="checkbox"/> HIV screening</li><li><input type="checkbox"/> Lung cancer with low dose computed tomography (LDCT) screening</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Medical nutrition therapy services</li><li><input type="checkbox"/> Medicare Diabetes Prevention Program (MDPP)</li><li><input type="checkbox"/> Obesity screenings and counseling</li><li><input type="checkbox"/> Prostate cancer screenings (PSA)</li><li><input type="checkbox"/> Sexually transmitted infections screenings and counseling</li><li><input type="checkbox"/> Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li><li><input type="checkbox"/> Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li><li><input type="checkbox"/> “Welcome to Medicare” preventive visit (one-time)</li></ul>

Any additional preventive services approved by Medicare during the contract year will be covered.

This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.

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### Emergency care

Depending on your level of Medicaid eligibility, \$0 copay or \$110 copay (\$0 copay for emergency care outside the United States) per visit. If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.


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### Urgently needed services



Depending on your level of Medicaid eligibility, \$0 copay or \$45 copay (\$0 copay for urgently needed services outside the United States) per visit

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## Medical benefits

		In-network	Out-of-network
<b>Diagnostic tests, lab and radiology services, and X-rays</b>	Diagnostic radiology services (e.g. MRI, CT scan) <sup>2</sup>	\$0 copay for each diagnostic mammogram Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance otherwise	\$0 copay for each diagnostic mammogram 20% coinsurance otherwise
	Lab services <sup>2</sup>	\$0 copay	\$0 copay
	Diagnostic tests and procedures <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Therapeutic radiology <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Outpatient X-rays <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
 <b>Hearing services</b>	Exam to diagnose and treat hearing and balance issues <sup>2</sup>	\$0 copay	\$0 copay
	Routine hearing exam	\$0 copay, 1 per year*	20% coinsurance, 1 per year*
	Hearing aids <sup>2</sup>	\$1,500 allowance every year for 2 hearing aids* <ul style="list-style-type: none"> <li><input type="checkbox"/> A broad selection of over-the-counter (OTC) and brand-name prescription hearing aids</li> <li><input type="checkbox"/> Access to one of the largest national networks of hearing professionals with more than 7,000 locations</li> <li><input type="checkbox"/> 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period</li> </ul>	

## Medical benefits

		In-network	Out-of-network
 <b>Routine dental benefits</b>	Preventive and comprehensive <sup>2</sup>	<p>\$1,500 allowance for all covered dental services*</p> <p>\$0 copay for covered preventive and comprehensive services like cleanings, fillings and crowns</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No annual deductible</li> <li><input type="checkbox"/> Access to one of the largest national dental networks</li> <li><input type="checkbox"/> Freedom to see any dentist</li> </ul>	
 <b>Vision services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup>	\$0 copay	20% coinsurance
	Eyewear after cataract surgery	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Routine eye exam	\$0 copay, 1 per year*	20% coinsurance, 1 per year*
	Routine eyewear	<p>\$150 allowance for 1 pair of frames or contacts*</p> <ul style="list-style-type: none"> <li>• Free standard prescription lenses including single vision, bifocals, trifocals and Tier I (standard) progressives – all with scratch-resistant coating</li> <li>• Access to one of Medicare Advantage’s largest national networks of vision providers and retail providers</li> <li>• Eyewear available from many online providers, including Warby Parker and GlassesUSA</li> </ul>	

Medical benefits			
		In-network	Out-of-network
<b>Mental health</b>	Inpatient visit <sup>2</sup> Our plan covers 90 days for an inpatient hospital stay	Depending upon your level of Medicaid eligibility, you pay \$0 copay per stay, or; \$1,485 copay per stay	\$1,485 copay per stay
	Outpatient group therapy visit <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Outpatient individual therapy visit <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Virtual mental health visits	\$0 copay to talk with a network telehealth provider online through live audio and video	
<b>Skilled nursing facility (SNF)<sup>2</sup></b> (Stay must meet Medicare coverage criteria) Our plan covers up to 100 days in a SNF.	Depending upon your level of Medicaid eligibility, you pay \$0 copay per day: days 1-100, or; You pay the Original Medicare cost sharing amount for 2025 which will be set by CMS in the fall of 2024. These are 2024 cost sharing amounts and may change for 2025. Our plan will provide updated rates as soon as they are released. \$0 copay per day: days 1-20 \$204 copay per day: days 21-100	40% coinsurance per stay, up to 100 days	

Medical benefits			
		In-network	Out-of-network
<b>Outpatient rehabilitation services</b>	Physical therapy and speech and language therapy visit <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Occupational Therapy Visit <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Virtual medical visits	\$0 copay to talk with a network telehealth provider online through live audio and video	
<b>Ambulance<sup>2</sup></b> Your provider must obtain prior authorization for non-emergency transportation.		Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance for ground Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance for air	20% coinsurance for ground 20% coinsurance for air
<b>Routine transportation</b>		\$0 copay for 36 one-way trips to or from approved medically related appointments and pharmacies*	75% coinsurance*
<b>Medicare Part B prescription drugs</b> In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	Chemotherapy drugs <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Part B covered insulin <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance, up to \$35	20% coinsurance
	Other Part B drugs <sup>2</sup> Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	\$0 copay for allergy antigens Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance for all others	\$0 copay for allergy antigens 20% coinsurance for all others



## Good news for 2025

The Coverage Gap, or "donut hole", has been eliminated and your out-of-pocket maximum cost is lower than ever. That means you're more protected from high drug costs in 2025.

### Prescription drug payment stages if you qualify for Low-Income Subsidy (LIS)

<b>Deductible</b>	Your deductible amount is \$0
<b>Initial Coverage</b>	<b>30-day<sup>^</sup> or 100-day supply from a retail network pharmacy</b>
Generic (including brand drugs treated as generic)	\$0, \$1.60, or \$4.90 copay (Some covered drugs are limited to a 30-day supply)
All other drugs <sup>3</sup>	\$0, \$4.80, or \$12.15 copay (Some covered drugs are limited to a 30-day supply)

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

<sup>3</sup>You will pay a maximum of \$35 for each 1-month supply of Part D covered insulin drugs through all drug payment stages, except the Catastrophic drug payment stage, where you pay \$0.


### Prescription drug payment stages if you do not qualify for LIS

<b>Deductible</b>	Your plan has a \$590 prescription drug deductible. You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage.		
<b>Initial Coverage</b>	In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,000, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage.		
<b>Drug coverage</b>	<b>Retail</b>	<b>Mail Order</b>	
	<b>30-day supply<sup>^</sup></b>	<b>100-day supply</b>	<b>100-day supply</b>
<b>All covered drugs<sup>3</sup></b>	25% coinsurance	25% coinsurance (Some covered drugs are limited to a 30-day supply)	25% coinsurance (Some covered drugs are limited to a 30-day supply)
<b>Catastrophic Coverage</b>	Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.		

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

<sup>3</sup>You will pay a maximum of \$35 for each 1-month supply of Part D covered insulin drugs through all drug payment stages, except the Catastrophic drug payment stage, where you pay \$0.

Additional benefits			
		In-network	Out-of-network
<b>Chiropractic services</b>	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
<b>Diabetes management</b>	Diabetes monitoring supplies <sup>2</sup>	<p>\$0 copay</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include: OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan.</p>	40% coinsurance
	Diabetes self-management training	\$0 copay	\$0 copay
	Therapeutic shoes or inserts <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	40% coinsurance
<b>Durable medical equipment (DME) and related supplies</b>	DME (e.g., wheelchairs, oxygen) <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	40% coinsurance

Additional benefits			
		In-network	Out-of-network
	Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	40% coinsurance
<b>Foot care</b> (podiatry services)	Foot exams and treatment <sup>2</sup>	\$0 copay	\$0 copay
	Routine foot care	\$0 copay, 6 visits per year*	\$0 copay, 6 visits per year*
<b>Meal benefit<sup>2</sup></b>		\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay	
<b>Home health care<sup>2</sup></b>		\$0 copay	40% coinsurance
<b>Hospice</b>		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.	
<b>Opioid treatment program services<sup>2</sup></b>		\$0 copay	\$0 copay
<b>Outpatient substance use disorder services</b>	Outpatient group therapy visit <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
	Outpatient individual therapy visit <sup>2</sup>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance
 <b>Over-the-counter (OTC) credit</b>	<p>\$35 credit every quarter for OTC products in-store or online</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Choose from thousands of brand name and generic OTC products like vitamins, pain relievers, first aid and more</li> <li><input type="checkbox"/> Shop at thousands of participating stores, including Walmart, Walgreens, Dollar General and Kroger, or at neighborhood stores near you</li> </ul>		

## Additional benefits

	In-network	Out-of-network
<b>Renal dialysis<sup>2</sup></b>	Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance	20% coinsurance

<sup>2</sup> May require your provider to get prior authorization from the plan for in-network benefits.

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

## Member discounts



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

## Plan deductible

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

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

## Annual medical deductible

Your deductible is the 2025 Original Medicare Part B deductible amount for covered medical services you receive from providers as described below. The 2024 Medicare deductible amount is \$240. The 2025 amount will be set by CMS in the fall of 2024. Our plan will provide updated rates as soon as they are released. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.

### Here's how it works:

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

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

### In-network

List of applicable services

#### Outpatient hospital

- Ambulatory surgical center (ASC), excluding diagnostic colonoscopy
- Outpatient hospital, including surgery, excluding diagnostic colonoscopy
- Outpatient hospital observation services

#### Doctor visits

- Primary
- Specialists

#### Diagnostic tests, lab and radiology services, and X-rays

- Diagnostic radiology services (e.g. MRI), excluding diagnostic mammogram
- Lab services
- Diagnostic tests and procedures
- Therapeutic radiology
- Outpatient X-rays

### Out-of-network

List of applicable services

#### Outpatient hospital

- Ambulatory surgical center (ASC)
- Outpatient hospital, including surgery
- Outpatient hospital observation services

#### Doctor visits

- Primary
- Specialists

#### Diagnostic tests, lab and radiology services, and X-rays

- Diagnostic radiology services (e.g. MRI)
- Lab services
- Diagnostic tests and procedures
- Therapeutic radiology
- Outpatient X-rays

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**Hearing services**

- Exam to diagnose and treat hearing and balance issues

**Hearing services**

- Exam to diagnose and treat hearing and balance issues

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**Vision services**

- Exam to diagnose and treat diseases and conditions of the eye
- Eyewear after cataract surgery

**Vision services**

- Exam to diagnose and treat diseases and conditions of the eye
- Eyewear after cataract surgery

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**Mental health**

- Outpatient group therapy visit
- Outpatient individual therapy visit

**Mental health**

- Outpatient group therapy visit
- Outpatient individual therapy visit

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

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**Ambulance****Ambulance**

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**Medicare Part B drugs**

- Chemotherapy drugs
- Other Part B drugs

**Medicare Part B drugs**

- Chemotherapy drugs
- Other Part B drugs

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**Chiropractic services**

- Manual manipulation of the spine to correct subluxation

**Chiropractic services**

- Manual manipulation of the spine to correct subluxation

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**Diabetes management**

- Diabetes monitoring supplies
- Therapeutic shoes or inserts

**Diabetes management**

- Diabetes monitoring supplies
- Diabetes self-management training
- Therapeutic shoes or inserts

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**Durable medical equipment (DME) and related supplies**

- Durable medical equipment (e.g. wheelchairs, oxygen)
- Prosthetics (e.g., braces, artificial limbs)

**Durable medical equipment (DME) and related supplies**

- Durable medical equipment (e.g. wheelchairs, oxygen)
- Prosthetics (e.g., braces, artificial limbs)

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**Foot care**

- Foot exams and treatment

**Foot care**

- Foot exams and treatment

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**Occupational therapy visit****Occupational therapy visit**

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**Opioid treatment program services****Opioid treatment program services**

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**Outpatient substance use disorder services**

- Outpatient group therapy visit
- Outpatient individual therapy visit

**Outpatient substance use disorder services**

- Outpatient group therapy visit
  - Outpatient individual therapy visit
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**Renal dialysis**

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**Renal dialysis**

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**Inpatient services**

- Inpatient hospital
  - Inpatient mental health
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**Skilled nursing facility (SNF)**

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**Home health care**

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## About this plan

UHC Complete Care Support AM-1A (Regional PPO C-SNP) is a Medicare Advantage RPPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live within our service area listed below, and be a United States citizen or lawfully present in the United States.

UHC Complete Care Support AM-1A (Regional PPO C-SNP) is a Chronic or Disabling Condition Special Needs Plan designed to specifically help people who have one or more of the following conditions: Cardiovascular Disorders, Chronic Heart Failure, and Diabetes.

Our service area includes **Arkansas, and Missouri.**

## Use network providers and pharmacies

UHC Complete Care Support AM-1A (Regional PPO C-SNP) has a network of doctors, hospitals, pharmacies and other providers. With this plan, you have the freedom to see any provider nationwide that accepts Medicare. Plus, you have the flexibility to access a network of local providers. You may pay a higher copay or coinsurance when you see an out-of-network provider. When looking at the charts above you'll see the cost differences for network vs. out-of-network care and services. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **UHC.com/Medicare** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.



## Required Information

UHC Complete Care Support AM-1A (Regional PPO C-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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 [www.medicare.gov](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.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-877-370-3207 for additional information (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunice con nosotros. Por ejemplo, documentos en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-877-370-3207, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 8 a.m. a 8 p.m.: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

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

### Hearing aids

Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider. Provider network size may vary by local market. OTC hearing aid warranties, if available, will vary by device and are handled through the manufacturer. One-time professional fee may apply for prescription hearing aids.

### Routine dental benefits

If your plan offers out-of-network dental coverage and you see an out-of-network dentist, you might be billed more. Provider network may vary in local market. Dental network size based on Zelis Network360, May 2023.

### Routine eyewear

Additional charges may apply for out-of-network items and services. Provider and retail network may vary in local market. Vision network size based on Zelis Network360, March 2023. Annual routine eye exam and \$100-450 allowance for contacts or designer frames, with standard (single, bi-focal, tri-focal or standard progressive) lenses covered in full either annually or every two years. Savings based on comparison to retail. Other vision providers are available in our network.

### Over-the-counter (OTC) credit

OTC benefits have expiration timeframes. Call your plan or review your Evidence of Coverage (EOC) for more information.

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

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

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You

are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

Additional authorizations may be required to access discount programs. The discounts described are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process. Discount offerings may vary by plan and are not available on all plans. The discount offers are made available to members through a third party. Participation in these third-party services are subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties.

**Rewards Program**

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