



Summary of Benefits 2026

UHC Dual Complete AL-V001 (HMO-POS D-SNP)
H0432-013-000

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



Toll-free 1-844-560-4944, TTY 711
8 a.m.-8 p.m. local time, 7 days a week

**United
Healthcare®**
Dual Complete

Summary of Benefits


January 1, 2026 - December 31, 2026



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

UHC Dual Complete AL-V001 (HMO-POS D-SNP)

| Medical premium, deductible and limits | | | |
|---|---|---|--|
| | | In-network | Out-of-network |
| Monthly plan premium | | \$16.60 | |
| Annual medical deductible | | This plan does not have a medical deductible. | |
| Maximum out-of-pocket amount (does not include prescription drugs) | | <p>\$6,700</p> <p>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers.</p> <p>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.</p> | |
| Medical benefits | | | |
| | | In-network | Out-of-network |
| Inpatient hospital care ² Our plan covers an unlimited number of days for an inpatient hospital stay. | | \$295 copay per day: days 1-7 \$0 copay per day: days 8 and beyond | \$295 copay per day: for days 1-7 \$0 copay per day: for days 8 and beyond [¥] |
| Outpatient hospital Cost-sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC) ² | \$0 copay for a colonoscopy \$245 copay otherwise | Not covered |
| | Outpatient hospital, including surgery ² | \$0 copay for a colonoscopy \$295 copay otherwise | \$0 copay for a colonoscopy \$295 copay otherwise [¥] |

| Medical benefits | | | |
|---|---|--|-------------------------------------|
| | | In-network | Out-of-network |
| | Outpatient hospital observation services ² | \$295 copay | \$295 copay [‡] |
| Doctor visits | Primary care provider | \$0 copay | \$0 copay [‡] |
| | Specialists ^{1,2} | \$30 copay | \$30 copay [‡] |
| | Virtual medical visits | \$0 copay to talk with a network telehealth provider online through live audio and video | |
| Preventive services | Routine physical | \$0 copay, 1 per year* | \$0 copay, 1 per year ^{*‡} |
| | Medicare-covered | \$0 copay | \$0 copay [‡] |
| | <div><div><div><input type="checkbox"/> Abdominal aortic aneurysm screening</div><div><input type="checkbox"/> Alcohol misuse counseling</div><div><input type="checkbox"/> Annual wellness visit</div><div><input type="checkbox"/> Bone mass measurement</div><div><input type="checkbox"/> Breast cancer screening (mammogram)</div><div><input type="checkbox"/> Cardiovascular disease (behavioral therapy)</div><div><input type="checkbox"/> Cardiovascular screening</div><div><input type="checkbox"/> Cervical and vaginal cancer screening</div><div><input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</div><div><input type="checkbox"/> Depression screening</div><div><input type="checkbox"/> Diabetes screenings and monitoring</div><div><input type="checkbox"/> Hepatitis C screening</div><div><input type="checkbox"/> HIV screening</div></div><div><div><input type="checkbox"/> Lung cancer with low dose computed tomography (LDCT) screening</div><div><input type="checkbox"/> Medical nutrition therapy services</div><div><input type="checkbox"/> Medicare Diabetes Prevention Program (MDPP)</div><div><input type="checkbox"/> Obesity screenings and counseling</div><div><input type="checkbox"/> Prostate cancer screenings (PSA)</div><div><input type="checkbox"/> Sexually transmitted infections screenings and counseling</div><div><input type="checkbox"/> Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</div><div><input type="checkbox"/> Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</div><div><input type="checkbox"/> “Welcome to Medicare” preventive visit (one-time)</div></div></div> | | |
| Any additional preventive services approved by Medicare during the contract year will be covered. | | | |

| Medical benefits | | | |
|--|--|---|---|
| | | In-network | Out-of-network |
| This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers. | | | |
| Emergency care | | \$130 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. | |
| Urgently needed services | | \$50 copay (\$0 copay for urgently needed services outside the United States) per visit | |
| Diagnostic tests, lab and radiology services, and X-rays | Diagnostic radiology services (e.g. MRI, CT scan) ² | \$0 copay for each diagnostic mammogram \$260 copay otherwise | \$0 copay for each diagnostic mammogram \$260 copay otherwise [¥] |
| | Lab services ² | \$0 copay | \$0 copay [¥] |
| | Diagnostic tests and procedures ² | \$50 copay | \$50 copay [¥] |
| | Therapeutic radiology ² | 20% coinsurance | 20% coinsurance [¥] |
| | Outpatient X-rays ² | \$25 copay | \$25 copay [¥] |
| | | | |
|  Hearing services | Exam to diagnose and treat hearing and balance issues ² | \$0 copay | Not covered |
| | Routine hearing exam | \$0 copay for a routine hearing exam to help support hearing health | Not covered |
| | Hearing aids ² | \$199 - \$829 copay for each OTC hearing aid. \$199 - \$1,249 copay for each prescription hearing aid. You can purchase up to 2 hearing aids every year. <ul style="list-style-type: none"> □ A broad selection of over-the-counter (OTC), high-value and brand-name prescription hearing aids □ Access to one of the largest national networks of hearing professionals with more than 6,500 locations | |

| Medical benefits | | | |
|--|--|--|----------------|
| | | In-network | Out-of-network |
| | | <input type="checkbox"/> 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period <input type="checkbox"/> Hearing aids purchased outside of UnitedHealthcare Hearing are not covered | |
|  Routine dental benefits | Preventive services | \$0 copay for covered preventive services like oral exams, X-rays, routine cleanings and fluoride: * <input type="checkbox"/> No annual deductible <input type="checkbox"/> Access to one of the largest national dental networks <input type="checkbox"/> Freedom to see any dentist | |
|  Vision services | Exam to diagnose and treat diseases and conditions of the eye ² | \$0 copay | Not covered |
| | Eyewear after cataract surgery | \$0 copay | Not covered |
| | Routine eye exam | \$0 copay for a routine eye exam each year to help protect your eyesight and health | Not covered |
| | Routine eyewear | \$150 allowance every 2 years for 1 pair of frames or contacts <input type="checkbox"/> Free standard prescription lenses including single vision, bifocals, trifocals and Tier I (standard) progressives <input type="checkbox"/> Other covered lenses available with copays from \$40 – \$153 <input type="checkbox"/> Access to one of Medicare Advantage’s largest national networks of vision providers and retail providers <input type="checkbox"/> Eyewear available from many online providers, including Warby Parker and GlassesUSA <input type="checkbox"/> You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network | |

| Medical benefits | | | |
|---|--|---|--------------------------------------|
| | | In-network | Out-of-network |
| Mental health | Inpatient visit ² Our plan covers 90 days for an inpatient hospital stay | \$295 copay per day: days 1-7 \$0 copay per day: days 8-90 | Not covered |
| | Outpatient group therapy visit ² | \$15 copay | Not covered |
| | Outpatient individual therapy visit ² | \$25 copay | Not covered |
| | Virtual mental health visits | \$0 copay to talk with a network telehealth provider online through live audio and video | |
| Skilled nursing facility (SNF)² Our plan covers up to 100 days in a SNF. | | \$0 copay per day: days 1-20 \$218 copay per day: days 21-100 | Not covered |
| Outpatient rehabilitation services | Physical therapy and speech and language therapy visit ^{1,2} | \$30 copay | \$30 copay [¥] |
| | Occupational Therapy Visit ^{1,2} | \$30 copay | \$30 copay [¥] |
| Ambulance² Your provider must obtain prior authorization for non-emergency transportation. | | \$290 copay for ground \$290 copay for air | Not covered (except for emergencies) |
| Routine transportation | | \$0 copay for 24 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies | Not covered |

| Medical benefits | | | |
|---|--|--|---|
| | | In-network | Out-of-network |
| Medicare Part B prescription drugs In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Chemotherapy drugs ² | 20% coinsurance | 20% coinsurance [¥] |
| | Part B covered insulin ² | 20% coinsurance, up to \$35 | 20% coinsurance [¥] |
| | Other Part B drugs ² Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | \$0 copay for allergy antigens 20% coinsurance for all others | \$0 copay for allergy antigens 20% coinsurance for all others [¥] |

| Prescription drugs | |
|--|---|
| If you don't qualify for Low-Income Subsidy (LIS), you pay the Medicare Part D cost-share outlined in the Evidence of Coverage. If you do qualify for Low-Income Subsidy (LIS) you pay: | |
| Deductible | Your deductible amount is \$0 |
| Initial Coverage | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,100, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. |
| Drug Coverage | 30-day^ or 100-day supply from a retail network pharmacy |
| Generic (including brand drugs treated as generic) | \$0, \$1.60, or \$5.10 copay Drugs that are in Tier 1 are always \$0 copay. (Some covered drugs are limited to a 30-day supply) |
| All other drugs ³ | \$0, \$4.90, or \$12.65 copay Drugs that are in Tier 1 are always \$0 copay. (Some covered drugs are limited to a 30-day supply) |

Prescription drugs

Catastrophic Coverage


Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.


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

³ You pay no more than 25% of the total drug cost or a \$35 copay, whichever is lower, for each 1-month supply of Part D covered insulin drugs, even if you haven't paid your deductible, until you reach the Catastrophic Coverage stage where you pay \$0.

Additional benefits

| | | In-network | Out-of-network |
|------------------------------|---|--|----------------|
| Chiropractic services | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) ² | \$15 copay | Not covered |
| Diabetes management | Diabetes monitoring supplies ² | <p>\$0 copay</p> <p>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.</p> <p>Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.</p> <p>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.</p> | Not covered |
| | Diabetes self-management training | \$0 copay | Not covered |

| Additional benefits | | | |
|--|---|---|----------------|
| | | In-network | Out-of-network |
| | Therapeutic shoes or inserts ² | 20% coinsurance | Not covered |
| Durable medical equipment (DME) and related supplies | DME (e.g., wheelchairs, oxygen) ² | 20% coinsurance | Not covered |
| | Prosthetics (e.g., braces, artificial limbs) ² | 20% coinsurance | Not covered |
|  Fitness program | | \$0 copay Your fitness program helps you stay active and connected at the gym, from home or in your community. It's available to you at no cost and includes: <ul style="list-style-type: none"> <input type="checkbox"/> Free gym membership at core locations <input type="checkbox"/> Access to a large national network of gyms and fitness locations <input type="checkbox"/> On-demand workout videos and live streaming fitness classes <input type="checkbox"/> Online memory fitness activities | |
| Foot care (podiatry services) | Foot exams and treatment ² | \$30 copay | Not covered |
| | Routine foot care | \$30 copay, 6 visits per year | Not covered |
| Meal benefit² | | \$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay | |
| Home health care² | | \$0 copay | Not covered |
| Hospice | | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan. | |
| Opioid treatment program services² | | \$0 copay | Not covered |


| Additional benefits | | | |
|--|--|--|--|
| | | In-network | Out-of-network |
| Outpatient substance use disorder services | Outpatient group therapy visit ² | \$15 copay | Not covered |
| | Outpatient individual therapy visit ² | \$25 copay | Not covered |
|  OTC, healthy food, utilities + wellness support | | \$35 credit every month for over-the-counter (OTC) products and wellness support, plus healthy food and utilities for qualifying members <ul style="list-style-type: none"> <input type="checkbox"/> Choose from thousands of OTC products, like first aid supplies, pain relievers and more <input type="checkbox"/> Buy healthy foods like fruits, vegetables, meat, seafood, dairy products and water <input type="checkbox"/> Shop at thousands of participating stores, including Walmart, Walgreens and Dollar General, or at neighborhood stores near you <input type="checkbox"/> Pay home utilities like electricity, heat, water and internet <input type="checkbox"/> Get wellness support including in-home services, weight management coaching, respite care, select fitness items and more | |
| Renal dialysis ² | | 20% coinsurance | Not covered out-of-network (except in emergency situations). |

¹ Requires a referral from your doctor.

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

* Benefits are combined in and out-of-network

¥ Out-of-network services are limited to Southeast Health providers or facilities only in Houston, Dale, and Henry counties

| 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. |

Medicaid Benefits

Information for people with Medicare and Medicaid. Your services are paid first by Medicare and then by Medicaid.

The benefits described below are covered by Medicaid. You can see what Alabama Medicaid covers and what our plan covers.

Coverage of the benefits depends on your level of Medicaid eligibility. If Medicare doesn't cover a service or a benefit has run out, Medicaid may help, but you may have to pay a cost share. In some situations, Medicaid may pay your Medicare cost sharing amount. See your Medicaid Member Handbook for more details. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Alabama Medicaid, 1-800-362-1504.

| Benefits | Medicaid | UHC Dual Complete AL-V001 (HMO-POS D-SNP) |
|--|-------------|---|
| Inpatient Hospital Care | Covered | Covered |
| Doctor Office Visits | Covered | Covered |
| Preventive Care | Covered | Covered |
| Emergency Care | Covered | Covered |
| Urgently Needed Services | Covered | Covered |
| Diagnostic Tests Lab and Radiology Services and X-Rays | Covered | Covered |
| Hearing Services | Not covered | Covered |
| Dental Services | Not covered | Covered |
| Vision Services | Covered | Covered |
| Inpatient Mental Health Care | Covered | Covered |
| Mental Health Care | Covered | Covered |
| Skilled Nursing Facility (SNF) | Covered | Covered |
| Ambulance | Covered | Covered |
| Transportation (Routine) | Covered | Covered |
| Prescription Drug Benefits | Covered | Covered |
| Chiropractic Care | Not covered | Covered with limitations |
| Diabetes Supplies and Services | Covered | Covered |
| Durable Medical Equipment | Covered | Covered |
| Foot Care | Covered | Covered |
| Home Health Care | Covered | Covered |
| Hospice | Covered | Covered |

| Benefits | Medicaid | UHC Dual Complete AL-V001 (HMO-POS D-SNP) |
|------------------------------|----------|---|
| Outpatient Hospital Services | Covered | Covered |
| Renal Dialysis | Covered | Covered |
| Prosthetic Devices | Covered | Covered |

About this plan

UHC Dual Complete AL-V001 (HMO-POS D-SNP) is a Medicare Advantage HMOPOS 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.

You can enroll in this plan if you are in one of these Medicaid categories:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A premium (under limited circumstances) and Part B premium, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays.
- **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A premium (under limited circumstances) and Part B premium, deductibles, coinsurance, and copayment amounts only for Medicare covered services. You pay nothing, except for Part D prescription drug copays.
- **Qualifying Individual (QI):** Medicaid pays your part B premium only. The State Medicaid Office does not pay your cost-share. You do not have full Medicaid benefits. You pay the cost share amounts listed in the chart above. There may be some services that do not have a member cost share amount.
- **Specified Low-Income Medicare Beneficiary (SLMB+):** Medicaid pays your Part B premium and provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from your state Medicaid agency in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Medicaid pays your Part B premium only. The State Medicaid Office does not pay your cost-share. You do not have full Medicaid benefits. There may be some services that do not have a member cost share amount.
- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

If your category of Medicaid eligibility changes, your cost share may also increase or decrease. You must recertify your Medicaid enrollment to continue to receive your Medicare coverage.

Our service area includes these counties in:

Alabama: Barbour, Bullock, Butler, Calhoun, Chambers, Cherokee, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Conecuh, Coosa, Covington, Crenshaw, Dale, Dallas, DeKalb, Elmore, Etowah, Fayette, Franklin, Geneva, Greene, Hale, Henry, Jackson, Lamar, Lauderdale, Lawrence,

Lee, Limestone, Marengo, Marion, Marshall, Monroe, Morgan, Perry, Pickens, Pike, Randolph, Sumter, Tallapoosa, Tuscaloosa, Washington, Wilcox, Winston.

Use network providers and pharmacies

UHC Dual Complete AL-V001 (HMO-POS D-SNP) has a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network. Out-of-network services are limited to the plan's service area as described on the cover. If you have any questions, please contact customer service. This health plan requires you to select a primary care provider (PCP) from the network. Your PCP can handle most routine health care needs and will be responsible to coordinate your care. If you need to see a network specialist or other network provider, you may need to get a referral from your PCP. We encourage you to find out which specialists and hospitals your PCP would recommend for you and would refer you to for care, prior to selecting them as your plan's PCP. 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](https://www.ahca.alabama.gov/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 Dual Complete AL-V001 (HMO-POS 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.

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 [medicare.gov](https://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 1-866-480-1086 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 comunique 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 1-866-480-1086, 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.

Fitness program

The fitness benefit and gym network varies by plan/area and participating locations may change. The fitness benefit includes a standard fitness membership at participating locations. Not all plans offer access to premium locations. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.

OTC, healthy food, utilities + wellness support

OTC, food and utility benefits have expiration timeframes. Review your Evidence of Coverage (EOC) for more information. The healthy food and utilities benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as diabetes, cardiovascular disorders, chronic heart

failure, chronic high blood pressure and/or chronic high cholesterol, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed. Certain wellness support services are provided by third parties not affiliated with UnitedHealthcare and participation may be subject to your acceptance of the third parties' respective terms and policies. UnitedHealthcare is not responsible for the services provided by third parties.

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.

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.