



# Summary of Benefits 2026

**UHC Dual Complete NY-S002 (HMO-POS D-SNP)**  
H3387-014-002

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/CommunityPlan**



**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 [myUHC.com/CommunityPlan](https://myUHC.com/CommunityPlan) 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 NY-S002 (HMO-POS D-SNP)

### Medical premium, deductible and limits

|                                                                           |                                                                                                                                              |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium</b>                                               | \$0<br>You may need to continue to pay your Medicare Part B premium                                                                          |
| <b>Part B premium reduction</b>                                           | Up to \$0.50<br>If your Medicare Part B premium is paid by Medicaid, or others on your behalf, you will not see the reduction.               |
| <b>Annual medical deductible</b>                                          | This plan does not have a medical deductible.                                                                                                |
| <b>Maximum out-of-pocket amount</b> (does not include prescription drugs) | \$0<br><br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers. |
| <b>Medicare cost-sharing</b>                                              | If you have full Medicaid benefits, you will pay \$0 for your Medicare-covered services as noted by the cost-sharing in this chart.          |

### Medical benefits

|                                             |                                                                                                   |
|---------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Inpatient hospital care</b> <sup>2</sup> | \$0 copay per stay<br>Our plan covers an unlimited number of days for an inpatient hospital stay. |
| <b>Outpatient hospital</b>                  | Ambulatory surgical center (ASC) <sup>2</sup> \$0 copay                                           |
|                                             | Outpatient hospital, including surgery <sup>2</sup> \$0 copay                                     |

## Medical benefits

Outpatient hospital observation services<sup>2</sup> \$0 copay

### Doctor visits

Primary care provider \$0 copay

Specialists<sup>1,2</sup> \$0 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

Medicare-covered \$0 copay

- |                                                                                                                      |                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Abdominal aortic aneurysm screening                                                         | <input type="checkbox"/> Lung cancer with low dose computed tomography (LDCT) screening                                   |
| <input type="checkbox"/> Alcohol misuse counseling                                                                   | <input type="checkbox"/> Medical nutrition therapy services                                                               |
| <input type="checkbox"/> Annual wellness visit                                                                       | <input type="checkbox"/> Medicare Diabetes Prevention Program (MDPP)                                                      |
| <input type="checkbox"/> Bone mass measurement                                                                       | <input type="checkbox"/> Obesity screenings and counseling                                                                |
| <input type="checkbox"/> Breast cancer screening (mammogram)                                                         | <input type="checkbox"/> Prostate cancer screenings (PSA)                                                                 |
| <input type="checkbox"/> Cardiovascular disease (behavioral therapy)                                                 | <input type="checkbox"/> Sexually transmitted infections screenings and counseling                                        |
| <input type="checkbox"/> Cardiovascular screening                                                                    | <input type="checkbox"/> Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) |
| <input type="checkbox"/> Cervical and vaginal cancer screening                                                       | <input type="checkbox"/> Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19                       |
| <input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) | <input type="checkbox"/> “Welcome to Medicare” preventive visit (one-time)                                                |
| <input type="checkbox"/> Depression screening                                                                        |                                                                                                                           |
| <input type="checkbox"/> Diabetes screenings and monitoring                                                          |                                                                                                                           |
| <input type="checkbox"/> Hepatitis C screening                                                                       |                                                                                                                           |
| <input type="checkbox"/> HIV screening                                                                               |                                                                                                                           |

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.

## Medical benefits

**Emergency care** \$0 copay (worldwide) 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** \$0 copay (worldwide) per visit

**Diagnostic tests, lab and radiology services, and X-rays** Diagnostic radiology services (e.g. MRI, CT scan)<sup>2</sup> \$0 copay

Lab services<sup>2</sup> \$0 copay

Diagnostic tests and procedures<sup>2</sup> \$0 copay

Therapeutic radiology<sup>2</sup> \$0 copay

Outpatient X-rays<sup>2</sup> \$0 copay



### Hearing services

Exam to diagnose and treat hearing and balance issues<sup>2</sup> \$0 copay

Routine hearing exam \$0 copay for a routine hearing exam to help support hearing health

Hearing aids<sup>2</sup> \$2,200 allowance for 2 hearing aids every 2 years

- ☐ 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
- ☐ 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period
- ☐ Hearing aids purchased outside of UnitedHealthcare Hearing are not covered

| Medical benefits                                                                                                                                      |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>Routine dental benefits</b><br><br>Covered in and out-of-network | Preventive and comprehensive services <sup>2</sup>                                         | \$0 copay for covered preventive and comprehensive services like cleanings, fillings, crowns, bridges and dentures* <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                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                       | Eyewear after cataract surgery                                                             | \$0 copay                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                       | Routine eye exam                                                                           | \$0 copay, 1 per year                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                       | Routine eyewear                                                                            | \$0 copay<br>Plan pays up to \$200 every year for 1 pair of lenses/frames and contacts                                                                                                                                                                                                                                                                                   |
| <b>Mental health</b>                                                                                                                                  | Inpatient visit <sup>2</sup><br><br>Our plan covers 90 days for an inpatient hospital stay | \$0 copay per stay                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                       | Outpatient group therapy visit <sup>2</sup>                                                | \$0 copay                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                       | Outpatient individual therapy visit <sup>2</sup>                                           | \$0 copay                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                       | 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><br>(Stay must meet Medicare coverage criteria)<br><br>Our plan covers up to 100 days in a SNF.      |                                                                                            | \$0 copay per day: days 1-100                                                                                                                                                                                                                                                                                                                                            |
| <b>Outpatient rehabilitation services</b>                                                                                                             | Physical therapy and speech and language therapy visit <sup>1,2</sup>                      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                |

## Medical benefits

|                                           |           |
|-------------------------------------------|-----------|
| Occupational Therapy Visit <sup>1,2</sup> | \$0 copay |
|-------------------------------------------|-----------|

### Ambulance<sup>2</sup>

Your provider must obtain prior authorization for non-emergency transportation.

|                      |
|----------------------|
| \$0 copay for ground |
| \$0 copay for air    |

### Routine transportation

\$0 copay for 12 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies

### Medicare Part B prescription drugs

|                                 |           |
|---------------------------------|-----------|
| Chemotherapy drugs <sup>2</sup> | \$0 copay |
|---------------------------------|-----------|

|                                     |           |
|-------------------------------------|-----------|
| Part B covered insulin <sup>2</sup> | \$0 copay |
|-------------------------------------|-----------|

|                                 |           |
|---------------------------------|-----------|
| Other Part B drugs <sup>2</sup> | \$0 copay |
|---------------------------------|-----------|

Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.

## 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:

|                   |                               |
|-------------------|-------------------------------|
| <b>Deductible</b> | Your deductible amount is \$0 |
|-------------------|-------------------------------|

|                         |                                                                                                                                                                                                                                                                         |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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 \$2,100, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                      |                                                                 |
|----------------------|-----------------------------------------------------------------|
| <b>Drug Coverage</b> | <b>30-day^ or 100-day supply from a retail network pharmacy</b> |
|----------------------|-----------------------------------------------------------------|

|                                                    |                                                                                                                                       |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| Generic (including brand drugs treated as generic) | \$0, \$1.60, or \$5.10 copay<br>Drugs that are in Tier 1 are always \$0 copay.<br>(Some covered drugs are limited to a 30-day supply) |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|

## Prescription drugs

All other drugs<sup>3</sup> \$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)

## 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.

<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 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

### Acupuncture services

Routine acupuncture services \$0 copay, 12 visits per year

### Chiropractic services

Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)<sup>2</sup> \$0 copay

Routine chiropractic services \$0 copay, 6 visits per year

### Diabetes management

Diabetes monitoring supplies<sup>2</sup> \$0 copay  
 We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.

Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.

Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.

Diabetes self-management training \$0 copay

| Additional benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Therapeutic shoes or inserts <sup>2</sup>                 | \$0 copay                                                                                                                                                                                            |
| <b>Durable medical equipment (DME) and related supplies</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DME (e.g., wheelchairs, oxygen) <sup>2</sup>              | \$0 copay                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Prosthetics (e.g., braces, artificial limbs) <sup>2</sup> | \$0 copay                                                                                                                                                                                            |
| <div>  <b>Fitness program</b> </div> <div> <p>\$0 copay</p> <p>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:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Free gym membership at core locations</li> <li><input type="checkbox"/> Access to a large national network of gyms and fitness locations</li> <li><input type="checkbox"/> On-demand workout videos and live streaming fitness classes</li> <li><input type="checkbox"/> Online memory fitness activities</li> </ul> </div> |                                                           |                                                                                                                                                                                                      |
| <b>Foot care</b><br>(podiatry services)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Foot exams and treatment <sup>2</sup>                     | \$0 copay                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Routine foot care                                         | \$0 copay, 4 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                                                                                                                                                                                            |
| <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                                                                                                                                                                                            |
| <b>Outpatient substance use disorder services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Outpatient group therapy visit <sup>2</sup>               | \$0 copay                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Outpatient individual therapy visit <sup>2</sup>          | \$0 copay                                                                                                                                                                                            |

**Additional benefits**



**OTC, healthy food, utilities + wellness support**

\$118 credit every month for over-the-counter (OTC) products and wellness support, plus healthy food and utilities for qualifying members

- ☐ Choose from thousands of OTC products, like first aid supplies, pain relievers and more
- ☐ Buy healthy foods like fruits, vegetables, meat, seafood, dairy products and water
- ☐ Shop at thousands of participating stores, including Walmart, Walgreens and Dollar General, or at neighborhood stores near you
- ☐ Pay home utilities like electricity, heat, water and internet
- ☐ Get wellness support including in-home services, weight management coaching, respite care, select fitness items and more

**Renal dialysis<sup>2</sup>**

\$0 copay

<sup>1</sup> Requires a referral from your doctor.

<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

## Medicaid Benefits

Information for people with Medicare and New York State Medicaid Fee-For-Service. For UHC Dual Complete members who are also members of a UHC Medicaid managed care plan, please refer to your UHC Community Plan member handbook for more information.

The benefits described below are covered by Medicaid. You can see what New York State's Medicaid Program covers and what our plan covers. Your services are paid first by Medicare and then by Medicaid.

**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 New York State Department of Health, 1-800-541-2831.

| Benefits                                                                      | Medicaid                 | UHC Dual Complete NY-S002 (HMO-POS D-SNP) |
|-------------------------------------------------------------------------------|--------------------------|-------------------------------------------|
| <b>Inpatient Hospital Care</b>                                                | Covered                  | Covered                                   |
| <b>Doctor Office Visits</b>                                                   | Covered                  | Covered                                   |
| <b>Preventive Care</b>                                                        | Covered                  | Covered                                   |
| <b>Emergency Care</b>                                                         | Covered                  | Covered                                   |
| <b>Urgently Needed Services</b>                                               | Covered                  | Covered                                   |
| <b>Diagnostic Tests Lab and Radiology Services and X-Rays</b>                 | Covered                  | Covered                                   |
| <b>Hearing Services</b>                                                       | Covered                  | Covered                                   |
| <b>Dental Services</b>                                                        | Covered with limitations | Covered                                   |
| <b>Vision Services</b>                                                        | Covered with limitations | Covered                                   |
| <b>Inpatient Mental Health Care</b>                                           | Covered                  | Covered                                   |
| <b>Mental Health Care</b>                                                     | Covered                  | Covered                                   |
| <b>Skilled Nursing Facility (SNF)</b>                                         | Covered                  | Covered                                   |
| <b>Ambulance</b>                                                              | Covered                  | Covered                                   |
| <b>Transportation (Routine)<br/>Provided by FFS Medicaid with limitations</b> | Covered                  | Covered                                   |
| <b>Prescription Drug Benefits<br/>Provided by NYRx</b>                        | Covered                  | Covered                                   |
| <b>Chiropractic Care</b>                                                      | Not covered              | Covered                                   |
| <b>Diabetes Supplies and Services</b>                                         | Covered with limitations | Covered                                   |
| <b>Durable Medical Equipment</b>                                              | Covered with limitations | Covered                                   |

| Benefits                     | Medicaid                 | UHC Dual Complete NY-S002 (HMO-POS D-SNP) |
|------------------------------|--------------------------|-------------------------------------------|
| Foot Care                    | Covered with limitations | Covered                                   |
| Home Health Care             | Covered                  | Covered                                   |
| Hospice                      | Covered                  | Covered                                   |
| Outpatient Hospital Services | Covered                  | Covered                                   |
| Renal Dialysis               | Covered                  | Covered                                   |
| Prosthetic Devices           | Covered with limitations | Covered                                   |

## About this plan

UHC Dual Complete NY-S002 (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.

This plan is a Dual Eligible Special Needs Plan (D-SNP) for people who have both Medicare and Medicaid, and don't pay anything for covered medical services. How much Medicaid covers depends on your income, resources, and other factors. Some people get full Medicaid benefits.

Your eligibility to enroll in this plan depends on your type of Medicaid.

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 and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays.
- **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:

**New York:** Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk.

## Use network providers and pharmacies

UHC Dual Complete NY-S002 (HMO-POS D-SNP) has a network of doctors, hospitals, pharmacies and other providers. For routine dental services, you can use providers that are not in our network. 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/CommunityPlan](https://www.uhc.com/CommunityPlan)** 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 NY-S002 (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 1-800-514-4912 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 1-800-514-4912, 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.

聯合健康保險提供免費服務以協助您與我們溝通。例如：其他語言版本、盲人點字、大字體、語音內容，或者，您可申請口譯員。如需其他資訊，請聯絡我們的客戶服務部，電話號碼 1-800-514-4912（聽力語言殘障服務專線（TTY）使用者請撥 711）。服務時間上午 8 時至晚上 8 時：10 月至 3 月每週 7 天；4 月至 9 月週一至週五。

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 size may vary by local market.

### 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.

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

**Rewards Program**

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