

# Summary of Benefits 2026

**UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP)**

H1045-065-000

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



**myPreferredCare.com**



**Toll-free 1-855-874-6282, TTY 711**

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



**Preferred  
Care Partners**

A UnitedHealthcare Company

# 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 [myPreferredCare.com](https://myPreferredCare.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 Preferred Dual Complete FL-Y3 (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 \$0.30<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><br>\$0 copay                                        |
|                                             | Outpatient hospital, including surgery <sup>2</sup><br>\$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>

\$3,200 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



### Routine dental benefits

Covered in and out-of-network

Preventive and comprehensive services<sup>2</sup>

\$5,000 allowance for all covered dental services\*

\$0 copay for covered preventive and comprehensive services like cleanings, fillings, crowns, bridges and dentures

- ☐ No annual deductible
- ☐ Access to one of the largest national dental networks
- ☐ Freedom to see any dentist



### Vision services

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  
Plan pays up to \$450 every year for lenses/frames and contacts.  
Home delivered eyewear available through select network providers (select products only).

### Mental health

Inpatient visit<sup>2</sup>  
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

### Skilled nursing facility (SNF)<sup>2</sup>

(Stay must meet Medicare coverage criteria)

Our plan covers up to 100 days in a SNF.

\$0 copay per day: days 1-100

| Medical benefits                                                                                                |                                                                       |                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Outpatient rehabilitation services</b>                                                                       | Physical therapy and speech and language therapy visit <sup>1,2</sup> | \$0 copay                                                                                               |
|                                                                                                                 | Occupational Therapy Visit <sup>1,2</sup>                             | \$0 copay                                                                                               |
| <b>Ambulance<sup>2</sup></b><br>Your provider must obtain prior authorization for non-emergency transportation. |                                                                       | \$0 copay for ground<br>\$0 copay for air                                                               |
| <b>Routine transportation</b>                                                                                   |                                                                       | \$0 copay for unlimited one-way trips to or from approved medically related appointments and pharmacies |
| <b>Medicare Part B prescription drugs</b>                                                                       | 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                                                                                               |

| Prescription drugs             |                                                                               |
|--------------------------------|-------------------------------------------------------------------------------|
| <b>Deductible</b>              | \$0                                                                           |
| <b>Drug Coverage</b>           | <b>30-day^ or 100-day supply from a retail or mail order network pharmacy</b> |
| All covered drugs <sup>3</sup> | \$0 copay<br>(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 pay a maximum of \$0 for each 1-month supply of Part D covered insulin.

## Additional benefits

### Chiropractic services

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

### 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

Therapeutic shoes or inserts<sup>2</sup> \$0 copay

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

DME (e.g., wheelchairs, oxygen)<sup>2</sup> \$0 copay

Prosthetics (e.g., braces, artificial limbs)<sup>2</sup> \$0 copay



### 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:

- ☐ Free gym membership at core and premium locations
- ☐ Access to a large national network of gyms and fitness locations

| Additional benefits                                                                                                                        |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                            |                                                  | <input type="checkbox"/> On-demand workout videos and live streaming fitness classes<br><input type="checkbox"/> Online memory fitness activities                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Foot care</b><br>(podiatry services)                                                                                                    | Foot exams and treatment <sup>2</sup>            | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                            | Routine foot care                                | \$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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|  <b>OTC, healthy food, utilities + wellness support</b> |                                                  | \$354 credit every month for over-the-counter (OTC) products and wellness support, plus healthy food and utilities for qualifying members<br><input type="checkbox"/> Choose from thousands of OTC products, like first aid supplies, pain relievers and more<br><input type="checkbox"/> Buy healthy foods like fruits, vegetables, meat, seafood, dairy products and water<br><input type="checkbox"/> Shop at thousands of participating stores, including Walmart, Walgreens and Dollar General, or at neighborhood stores near you<br><input type="checkbox"/> Pay home utilities like electricity, heat, water and internet<br><input type="checkbox"/> Get wellness support including in-home services, weight management coaching, respite care, select fitness items and more |
| <b>Renal dialysis<sup>2</sup></b>                                                                                                          |                                                  | \$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 Medicaid. Your services are paid first by Medicare and then by Medicaid.

The benefits described below are covered by Medicaid. You can see what Florida Medicaid Agency for Health Care Administration (AHCA) 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 Florida Department of Children and Families, 1-850-300-4323.

| Benefits                       | Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                  | UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP) |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| <b>Inpatient Hospital Care</b> | Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.<br><br>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br>\$0 co-pay for Medicaid services (Including assistive care services)                                                                                                            | Covered                                           |
| <b>Doctor Office Visits</b>    | Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.<br><br>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br>\$0 co-pay for Medicaid services<br>Including screening services, rural health services, federally qualified health centers, clinic services, and physician assistant services. | Covered                                           |

| <b>Benefits</b>                                               | <b>Medicaid</b>                                                                                                                                                                                                                                                                                                    | <b>UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP)</b> |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <b>Outpatient Surgery</b>                                     | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br/>\$0 co-pay for Medicaid services</p> | Covered                                                  |
| <b>Emergency Care</b>                                         | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br/>\$0 co-pay for Medicaid services</p> | Covered                                                  |
| <b>Urgently Needed Services</b>                               | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br/>\$0 co-pay for Medicaid services</p> | Covered                                                  |
| <b>Diagnostic Tests Lab and Radiology Services and X-Rays</b> | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:</p>                                      | Covered                                                  |

| Benefits                | Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP) |
|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
|                         | \$0 co-pay for Medicaid services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                   |
| <b>Hearing Services</b> | Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Covered                                           |
| <b>Dental Services</b>  | Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Covered                                           |
| <b>Vision Services</b>  | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:</p> <p>\$0 co-pay for Medicaid services including up to one routine vision exam, up to one pair of frames (includes Medicaid covered eyeglass lenses and frames) per year, and in total up to two pairs of lenses (includes Medicaid covered lenses) per year, or contact lenses (if medically necessary).</p> <p>Prior authorization may be required and must be received by a participating vision provider.</p> | Covered                                           |
| <b>Preventive Care</b>  | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:</p>                                                                                                                                                                                                                                                                                                                                                                                                                | Covered                                           |

| Benefits                                                                                                                                                                                                       | Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
|                                                                                                                                                                                                                | \$0 co-pay for Medicaid services                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                   |
| <b>Mental Health Care</b><br><input type="checkbox"/> Behavioral Health Targeted Case Management<br><input type="checkbox"/> Community Mental Health<br><input type="checkbox"/> Mental Health Case Management | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br/>\$0 co-pay for Medicaid services</p>                                                                                                                                                                  | Covered                                           |
| <b>Outpatient Rehabilitation</b>                                                                                                                                                                               | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br/>\$0 co-pay for Medicaid services<br/>Including registered physical therapist, physical therapy services, speech therapy services, occupational therapy services, and respiratory therapy services</p> | Covered                                           |
| <b>Ambulance</b>                                                                                                                                                                                               | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br/>\$0 co-pay for Medicaid services</p>                                                                                                                                                                  | Covered                                           |
| <b>Transportation (Routine)</b>                                                                                                                                                                                | \$0 co-pay for Medicaid services                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Covered                                           |

| Benefits                                                     | Medicaid                                                                                                                                                                                                                                                                                               | UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP) |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
|                                                              | For enrollees who qualify for additional Medicaid benefits, Medicaid pays unlimited trips for this service if it is not covered by Medicare or when the Medicare benefit is exhausted when provided by a participating transportation provider.                                                        |                                                   |
| <b>Prescription Drug Benefits</b>                            | Medicaid does not cover Part D covered drugs.                                                                                                                                                                                                                                                          | Covered                                           |
| <b>Chiropractic Services</b>                                 | Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.<br>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br>\$0 co-pay for Medicaid services | Covered                                           |
| <b>Diabetes Supplies and Services</b>                        | Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.<br>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:<br>\$0 co-pay for Medicaid services | Covered                                           |
| <b>Durable Medical Equipment (Wheelchairs, oxygen, etc.)</b> | Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.<br>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide                                                                                                      | Covered                                           |

| Benefits                              | Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                               | UHC Preferred Dual<br>Complete FL-Y3 (HMO-<br>POS D-SNP) |
|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
|                                       | additional coverage subject to the<br>following cost share amounts:<br>\$0 co-pay for Medicaid services                                                                                                                                                                                                                                                                                                                                                                |                                                          |
| <b>Foot Care (Podiatry services)</b>  | Depending on your level of<br>Medicaid eligibility, Medicaid may<br>pay your Medicare cost sharing<br>amount.<br>For services not covered by<br>Medicare or if the benefit is<br>exhausted, Medicaid may provide<br>additional coverage subject to the<br>following cost share amounts:<br>\$0 co-pay for Medicaid services                                                                                                                                            | Covered                                                  |
| <b>Skilled Nursing Facility (SNF)</b> | Depending on your level of<br>Medicaid eligibility, Medicaid may<br>pay your Medicare cost sharing<br>amount.<br>For services not covered by<br>Medicare or if the benefit is<br>exhausted, Medicaid may provide<br>additional coverage subject to the<br>following cost share amounts:<br>\$0 co-pay for Medicaid services<br>Including physical therapy<br>services, speech therapy services,<br>occupational therapy services, and<br>respiratory therapy services. | Covered                                                  |
| <b>Hospice</b>                        | Depending on your level of<br>Medicaid eligibility, Medicaid may<br>pay your Medicare cost sharing<br>amount.<br>For services not covered by<br>Medicare or if the benefit is<br>exhausted, Medicaid may provide<br>additional coverage subject to the<br>following cost share amounts:<br>\$0 co-pay for Medicaid services                                                                                                                                            | Covered                                                  |

| <b>Benefits</b>                                            | <b>Medicaid</b>                                                                                                                                                                                                                                                                                                       | <b>UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP)</b> |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <b>Renal Dialysis</b>                                      | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:</p> <p>\$0 co-pay for Medicaid services</p> | Covered                                                  |
| <b>Prosthetic Devices (Braces, artificial limbs, etc.)</b> | <p>Depending on your level of Medicaid eligibility, Medicaid may pay your Medicare cost sharing amount.</p> <p>For services not covered by Medicare or if the benefit is exhausted, Medicaid may provide additional coverage subject to the following cost share amounts:</p> <p>\$0 co-pay for Medicaid services</p> | Covered                                                  |
| <b>Over-the-Counter Items (with prescription)</b>          | \$0 co-pay for Medicaid services                                                                                                                                                                                                                                                                                      | Covered                                                  |

## About this plan

UHC Preferred Dual Complete FL-Y3 (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 (if applicable).
- **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.
- **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 the following county in:

**Florida:** Palm Beach.

## Use network providers and pharmacies

UHC Preferred Dual Complete FL-Y3 (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 **myPreferredCare.com** 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 Preferred Dual Complete FL-Y3 (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 1-855-245-5196 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 1-855-245-5196, 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.

### 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.