



Summary of Benefits 2026

UHC Dual Complete IN-D001 (PPO D-SNP)
H2385-002-000

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



UHC.com/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 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 IN-D001 (PPO D-SNP)

Medical premium, deductible and limits		
	In-network	Out-of-network
Monthly plan premium	\$38.40	
Part B premium reduction	Up to \$1 If your Medicare Part B premium is paid by Medicaid, or others on your behalf, you will not see the reduction.	
Annual medical deductible	Your medical deductible is \$283 combined in and out-of-network as described in the Plan Deductible chart later in this document. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.	
Maximum out-of-pocket amount (does not include prescription drugs)	\$9,250	\$13,900
	This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers.	This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from any provider.
	If you reach this amount, you will still need to pay your monthly premiums. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount.	

Medical premium, deductible and limits

	In-network	Out-of-network
Medicare cost-sharing	If you have full Medicaid benefits or are a Qualified Medicare Beneficiary (QMB), you will pay \$0 for your Medicare-covered services as noted by the cost-sharing in this chart.	If you are a QMB or have full Medicaid benefits and your provider accepts Medicaid, you will pay \$0 for your Medicare-covered services. Otherwise, you will pay the cost-sharing amount as noted in this chart.

Medical benefits

		In-network	Out-of-network
Inpatient hospital care² Our plan covers an unlimited number of days for an inpatient hospital stay.		\$0 copay per stay, or \$2,165 copay per stay	\$2,165 copay per stay
Outpatient hospital Cost-sharing for additional plan covered services will apply.	Ambulatory surgical center (ASC) ²	\$0 copay for a colonoscopy \$0 copay or 20% coinsurance otherwise	40% coinsurance
	Outpatient hospital, including surgery ²	\$0 copay for a colonoscopy \$0 copay or 20% coinsurance otherwise	40% coinsurance
	Outpatient hospital observation services ²	\$0 copay or 20% coinsurance	40% coinsurance
Doctor visits	Primary care provider	\$0 copay or 20% coinsurance	30% coinsurance
	Specialists ²	\$0 copay or 20% coinsurance	30% coinsurance
	Virtual medical visits	\$0 copay to talk with a network telehealth provider online through live audio and video	

Medical benefits			
		In-network	Out-of-network
Preventive services	Routine physical	\$0 copay, 1 per year*	40% coinsurance, 1 per year*
	Medicare-covered	\$0 copay	\$0 copay - 40% coinsurance (depending on the service)
	• Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screening • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings and monitoring • Hepatitis C screening • HIV screening	• Lung cancer with low dose computed tomography (LDCT) screening • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screenings and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screenings and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19 • “Welcome to Medicare” preventive visit (one-time)	
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.			
Emergency care		\$0 copay or \$115 copay (\$0 copay for emergency care outside the United States) per visit. If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.	

Medical benefits			
		In-network	Out-of-network
Urgently needed services		\$0 copay or \$40 copay (\$0 copay for urgently needed services outside the United States) per visit	
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (e.g. MRI, CT scan) ²	\$0 copay for each diagnostic mammogram \$0 copay or 20% coinsurance otherwise	40% coinsurance
	Lab services ²	\$0 copay	\$0 copay
	Diagnostic tests and procedures ²	\$0 copay or 20% coinsurance	40% coinsurance
	Therapeutic radiology ²	\$0 copay or 20% coinsurance	20% coinsurance
	Outpatient X-rays ²	\$0 copay or 20% coinsurance	40% coinsurance
 Hearing services	Exam to diagnose and treat hearing and balance issues ²	\$0 copay or 20% coinsurance	30% coinsurance
	Routine hearing exam	\$0 copay for a routine hearing exam to help support hearing health *	30% coinsurance for a routine hearing exam to help support hearing health *
	Hearing aids ²	\$1,500 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			
		In-network	Out-of-network
 Routine dental benefits	Preventive services	\$0 copay for covered preventive services like oral exams, X-rays, routine cleanings and fluoride.* • 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 ²	\$0 copay	30% coinsurance
	Eyewear after cataract surgery	\$0 copay	40% coinsurance
	Routine eye exam	\$0 copay, 1 per year*	30% coinsurance, 1 per year*
	Routine eyewear	\$0 copay Plan pays up to \$200 every year for 1 pair of lenses/frames and contacts.*	\$0 copay Plan pays up to \$200 every year for 1 pair of lenses/frames and contacts.*
Mental health	Inpatient visit ² Our plan covers 90 days for an inpatient hospital stay	\$0 copay per stay, or \$2,080 copay per stay	\$2,080 copay per stay
	Outpatient group therapy visit ²	\$0 copay or 20% coinsurance	30% coinsurance
	Outpatient individual therapy visit ²	\$0 copay or 20% coinsurance	30% coinsurance
	Virtual mental health visits	\$0 copay to talk with a network telehealth provider online through live audio and video	
Skilled nursing facility (SNF)² (Stay must meet Medicare coverage criteria) Our plan covers up to 100 days in a SNF.		\$0 copay per day: days 1-100, or \$0 copay per day: days 1-20 \$217 copay per day: days 21-100	\$0 copay per day: days 1-20 \$217 copay per day: days 21-100

Medical benefits			
		In-network	Out-of-network
Outpatient rehabilitation services	Physical therapy and speech and language therapy visit ²	\$0 copay or 20% coinsurance	30% coinsurance
	Occupational Therapy Visit ²	\$0 copay or 20% coinsurance	30% coinsurance
Ambulance² Your provider must obtain prior authorization for non-emergency transportation.		\$0 copay or 20% coinsurance for ground \$0 copay or 20% coinsurance for air	20% coinsurance for ground 20% coinsurance for air
Routine transportation		\$0 copay for 24 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies*	75% coinsurance*
Medicare Part B prescription drugs In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.	Chemotherapy drugs ²	\$0 copay or 20% coinsurance	20% coinsurance
	Part B covered insulin ²	\$0 copay or 20% coinsurance, up to \$35	20% coinsurance
	Other Part B drugs ² Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	\$0 copay or 20% coinsurance	20% coinsurance

Prescription drugs

If you don't qualify for Low-Income Subsidy (LIS), you pay the Medicare Part D cost-share outlined in the Evidence of Coverage. If you do qualify for Low-Income Subsidy (LIS) you pay:

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

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

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

Additional benefits			
		In-network	Out-of-network
Chiropractic services	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) ²	\$0 copay or 20% coinsurance	30% coinsurance
Diabetes management	Diabetes monitoring supplies ²	\$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,	20% coinsurance

Additional benefits			
		In-network	Out-of-network
		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	40% coinsurance
	Therapeutic shoes or inserts ²	\$0 copay or 20% coinsurance	20% coinsurance
Durable medical equipment (DME) and related supplies	DME (e.g., wheelchairs, oxygen) ²	\$0 copay or 20% coinsurance	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs) ²	\$0 copay or 20% coinsurance	20% coinsurance
 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 • On-demand workout videos and live streaming fitness classes • Online memory fitness activities	
Foot care (podiatry services)	Foot exams and treatment ²	\$0 copay or 20% coinsurance	30% coinsurance
	Routine foot care	\$0 copay, 6 visits per year*	30% coinsurance, 6 visits per year*

Additional benefits			
		In-network	Out-of-network
Meal benefit²		\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay	
Home health care²		\$0 copay	\$0 copay
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.	
Opioid treatment program services²		\$0 copay	\$0 copay
Outpatient substance use disorder services	Outpatient group therapy visit ²	\$0 copay or 20% coinsurance	30% coinsurance
	Outpatient individual therapy visit ²	\$0 copay or 20% coinsurance	30% coinsurance
 OTC, healthy food, utilities + wellness support		\$93 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 • If you use an out-of-network provider for in-home services, weight management coaching or respite care, you pay 75% coinsurance	
Renal dialysis²		\$0 copay or 20% coinsurance	20% coinsurance

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

* Benefits are combined in and out-of-network

Plan deductible

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

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

Annual medical deductible

Your deductible is \$283 per year for covered medical services you receive from providers as described below. Until you have paid the deductible amount, you must pay the full cost of your covered medical services.

Here's how it works:

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

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

In-network List of applicable services	Out-of-network List of applicable services
Outpatient hospital • Ambulatory surgical center (ASC), excluding diagnostic colonoscopy • Outpatient hospital, including surgery, excluding diagnostic colonoscopy • Outpatient hospital observation services	Outpatient hospital • Ambulatory surgical center (ASC) • Outpatient hospital, including surgery • Outpatient hospital observation services
Doctor visits • Primary • Specialists	Doctor visits • Primary • Specialists
Diagnostic tests, lab and radiology services, and X-rays • Diagnostic radiology services (e.g. MRI), excluding diagnostic mammogram and in-home vascular screening • Lab services • Diagnostic tests and procedures • Therapeutic radiology • Outpatient X-rays	Diagnostic tests, lab and radiology services, and X-rays • Diagnostic radiology services (e.g. MRI) • Lab services • Diagnostic tests and procedures • Therapeutic radiology • Outpatient X-rays
Hearing services	Hearing services

• Exam to diagnose and treat hearing and balance issues	• Exam to diagnose and treat hearing and balance issues
Vision services • Exam to diagnose and treat diseases and conditions of the eye • Eyewear after cataract surgery	Vision services • Exam to diagnose and treat diseases and conditions of the eye • Eyewear after cataract surgery
Mental health • Outpatient group therapy visit • Outpatient individual therapy visit	Mental health • Outpatient group therapy visit • Outpatient individual therapy visit
Physical therapy and speech and language therapy visit	Physical therapy and speech and language therapy visit
Ambulance	Ambulance
Medicare Part B drugs • Chemotherapy drugs • Other Part B drugs	Medicare Part B drugs • Chemotherapy drugs • Other Part B drugs
Chiropractic services • Manual manipulation of the spine to correct subluxation	Chiropractic services • Manual manipulation of the spine to correct subluxation
Diabetes management • Diabetes monitoring supplies • Therapeutic shoes or inserts	Diabetes management • Diabetes monitoring supplies • Diabetes self-management training • Therapeutic shoes or inserts
Durable medical equipment (DME) and related supplies • Durable medical equipment (e.g. wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs)	Durable medical equipment (DME) and related supplies • Durable medical equipment (e.g. wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs)
Foot care • Foot exams and treatment	Foot care • Foot exams and treatment
Occupational therapy visit	Occupational therapy visit
Opioid treatment program services	Opioid treatment program services
Outpatient substance use disorder services • Outpatient group therapy visit • Outpatient individual therapy visit	Outpatient substance use disorder services • Outpatient group therapy visit • Outpatient individual therapy visit
Renal dialysis	Renal dialysis

Inpatient services

- Inpatient hospital
- Inpatient mental health

Skilled nursing facility (SNF)

Home health care

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 Indiana Family and Social Services Administration 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 Indiana Family and Social Services Administration, 1-800-403-0864.

Benefits	Medicaid	UHC Dual Complete IN-D001 (PPO D-SNP)
Inpatient Hospital Care	Covered	Covered
Doctor Office Visits	Covered	Covered
Preventive Care	Covered	Covered
Emergency Care	Covered	Covered
Urgently Needed Services	Covered	Covered
Diagnostic Tests Lab and Radiology Services and X-Rays	Covered	Covered
Hearing Services	Covered	Covered
Dental Services	Covered	Covered
Vision Services	Covered	Covered
Inpatient Mental Health Care	Covered	Covered
Mental Health Care	Covered	Covered
Skilled Nursing Facility (SNF)	Covered	Covered
Ambulance	Covered	Covered
Transportation (Routine)	Covered	Covered
Prescription Drug Benefits	Covered	Covered
Chiropractic Care	Covered	Covered with limitations
Diabetes Supplies and Services	Covered	Covered
Durable Medical Equipment	Covered	Covered
Foot Care	Covered	Covered
Home Health Care	Covered	Covered
Hospice	Covered	Covered

Benefits	Medicaid	UHC Dual Complete IN-D001 (PPO D-SNP)
Outpatient Hospital Services	Covered	Covered
Renal Dialysis	Covered	Covered
Prosthetic Devices	Covered	Covered

About this plan

UHC Dual Complete IN-D001 (PPO D-SNP) is a Medicare Advantage PPO 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. How much Medicaid covers depends on your income, resources, and other factors.

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

- **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only for Medicare covered services. You pay nothing, except for Part D prescription drug copays.
- **Qualified Disabled and Working Individual (QDWI):** Medicaid pays your Part A premium only. The State Medicaid Office does not pay your cost-share. You do not have full Medicaid benefits. There may be some services that do not have a member cost share amount.
- **Qualifying Individual (QI):** Medicaid pays your part B premium only. The State Medicaid Office does not pay your cost-share. You do not have full Medicaid benefits. You pay the cost share amounts listed in the chart above. There may be some services that do not have a member cost share amount.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Medicaid pays your Part B premium only. The State Medicaid Office does not pay your cost-share. You do not have full Medicaid benefits. There may be some services that do not have a member cost share amount.

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:

Indiana: Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, Dearborn, Decatur, DeKalb, Delaware, Dubois, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, Lagrange, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Shelby, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Tipton, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, Whitley.

Use network providers and pharmacies

UHC Dual Complete IN-D001 (PPO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. With this plan, you have the freedom to see any provider nationwide that accepts Medicare. Plus, you have the flexibility to access a network of local providers. You may pay a higher copay or coinsurance when you see an out-of-network provider. When looking at the charts above you'll see the cost differences for network vs. out-of-network care and services. If you use

pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **UHC.com/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 IN-D001 (PPO 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 1-800-832-4643 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 comuniquen 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 1-800-832-4643, 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 2025.

Fitness program

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

OTC, healthy food, utilities + wellness support

OTC, food and utility benefits have expiration timeframes. Review your Evidence of Coverage (EOC) for more information. The healthy food and utilities benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as diabetes, cardiovascular disorders, chronic heart failure, chronic high blood pressure and/or chronic high cholesterol, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed. Certain wellness support services are provided by third parties not affiliated with UnitedHealthcare and participation may be subject to your acceptance of the third parties' respective terms and policies. UnitedHealthcare is not responsible for the services provided by third parties.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage

for more information, including the cost-sharing that applies to out-of-network services.

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

Rewards Program

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