

# Summary of Benefits 2027

AARP® Medicare Advantage Patriot No Rx NC-MA02 (HMO-POS)

H5253-040-000



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



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# Summary of Benefits

January 1, 2027 - December 31, 2027

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 [myAARPMedicare.com](https://myAARPMedicare.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.

## AARP® Medicare Advantage Patriot No Rx NC-MA02 (HMO-POS)

| Medical premium and limits   |                                                                                                                                              |                                                                                                                                         |
|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
|                              | In-network                                                                                                                                   | Out-of-network                                                                                                                          |
| Monthly plan premium         | \$0<br>You need to continue to pay your Medicare Part B premium                                                                              |                                                                                                                                         |
| Part B premium reduction     | Up to \$190<br>Reductions will be applied to your Social Security check or your Medicare Part B premium bill.                                |                                                                                                                                         |
| Annual medical deductible    | This plan does not have a medical deductible.                                                                                                |                                                                                                                                         |
| Maximum out-of-pocket amount | \$9,300<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers. | \$9,300<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from any provider. |

| Medical benefits                                                                                                          |                                                     |                                                                       |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
|                                                                                                                           |                                                     | In-network                                                            | Out-of-network                                                                             |
| <b>Inpatient hospital care<sup>2</sup></b><br>Our plan covers an unlimited number of days for an inpatient hospital stay. |                                                     | \$610 copay per day: days 1-4<br>\$0 copay per day: days 5 and beyond | \$610 copay per day: for days 1-4<br>\$0 copay per day: for days 5 and beyond <sup>‡</sup> |
| <b>Outpatient hospital</b><br>Cost-sharing for additional plan covered services will apply.                               | Ambulatory surgical center (ASC) <sup>2</sup>       | \$0 copay for a colonoscopy<br>\$510 copay otherwise                  | Not covered                                                                                |
|                                                                                                                           | Outpatient hospital, including surgery <sup>2</sup> | \$0 copay for a colonoscopy<br>\$610 copay otherwise                  | \$0 copay for a colonoscopy<br>\$610 copay otherwise <sup>‡</sup>                          |

| Medical benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                       |                                                                                                                  |                                                                                    |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                       | In-network                                                                                                       | Out-of-network                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Outpatient hospital observation services <sup>2</sup> | \$610 copay                                                                                                      | \$610 copay*                                                                       |
| Doctor visits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Primary care provider                                 | \$0 copay                                                                                                        | Not covered                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Specialists <sup>1,2</sup>                            | \$55 copay                                                                                                       | Not covered                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Virtual medical visits                                | \$0 copay                                                                                                        | Same as a Doctor's office visit                                                    |
| Preventive services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Routine physical                                      | \$0 copay, 1 per year                                                                                            | No coverage                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Medicare-covered                                      | \$0 copay                                                                                                        | Flu, pneumonia, or COVID-19 vaccines: \$0 copay<br>All other services: Not covered |
| <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse counseling</li> <li>• Annual wellness visit</li> <li>• Bone mass measurement</li> <li>• Breast cancer screening (mammogram)</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cardiovascular screening</li> <li>• Cervical and vaginal cancer screening</li> <li>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>• Depression screening</li> <li>• Diabetes screenings and monitoring</li> <li>• Hepatitis C screening</li> <li>• HIV screening</li> <li>• Lung cancer with low dose computed tomography (LDCT) screening</li> <li>• Medical nutrition therapy services</li> <li>• Medicare Diabetes Prevention Program (MDPP)</li> <li>• Obesity screenings and counseling</li> <li>• Prostate cancer screenings (PSA)</li> <li>• Sexually transmitted infections screenings and counseling</li> <li>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>• Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li> <li>• "Welcome to Medicare" preventive visit (one-time)</li> </ul> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.</p> |                                                       |                                                                                                                  |                                                                                    |
| Emergency care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                       | \$115 copay per visit. If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay |                                                                                    |

| Medical benefits                                                                                          |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|                                                                                                           |                                                                    | In-network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Out-of-network |
|                                                                                                           |                                                                    | instead of the Emergency Care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.                                                                                                                                                                                                                                                                                                                                                                                                                  |                |
| Urgently needed services                                                                                  |                                                                    | \$40 copay per visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |
| Diagnostic tests, lab and radiology services, and X-rays                                                  | Diagnostic radiology services (e.g. MRI, CT scan) <sup>2</sup>     | \$0 copay for each diagnostic mammogram<br>\$320 copay otherwise                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Not covered    |
|                                                                                                           | Lab services <sup>2</sup>                                          | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Not covered    |
|                                                                                                           | Diagnostic tests and procedures <sup>2</sup>                       | \$50 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Not covered    |
|                                                                                                           | Therapeutic radiology <sup>2</sup>                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Not covered    |
|                                                                                                           | Outpatient X-rays <sup>2</sup>                                     | \$30 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Not covered    |
|                                                                                                           |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                |
|  <b>Hearing services</b> | Exam to diagnose and treat hearing and balance issues <sup>2</sup> | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Not covered    |
|                                                                                                           | Routine hearing exam                                               | \$0 copay for a routine hearing exam to help support hearing health                                                                                                                                                                                                                                                                                                                                                                                                                                                              | No coverage    |
|                                                                                                           | Hearing aids <sup>2</sup>                                          | \$1,000 allowance for 2 hearing aids every year <ul style="list-style-type: none"> <li>• A broad selection of high-value and brand name prescription hearing aids</li> <li>• Access to one of the largest national networks of hearing professionals with more than 6,500 locations</li> <li>• 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period</li> <li>• Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.</li> </ul> | No coverage    |

## Medical benefits

|                                                                                                                  |                                                                            | In-network                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Out-of-network |
|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|  <b>Routine dental benefits</b> | Preventive and comprehensive services                                      | \$1,000 allowance for all covered dental services*<br>\$0 copay for covered preventive services like oral exams, X-rays, routine cleanings and fluoride                                                                                                                                                                                                                                                                                                               |                |
|                                                                                                                  |                                                                            | 50% coinsurance for covered comprehensive services like fillings, crowns, bridges and dentures <ul style="list-style-type: none"> <li>• No annual deductible</li> <li>• Access to one of the largest national dental networks</li> <li>• 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                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Not covered    |
|                                                                                                                  | Eyewear after cataract surgery                                             | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Not covered    |
|                                                                                                                  | Routine eye exam                                                           | \$0 copay for a routine eye exam each year to help protect your eyesight and health                                                                                                                                                                                                                                                                                                                                                                                   | No coverage    |
|                                                                                                                  | Routine eyewear                                                            | \$300 allowance every 2 years for 1 pair of eyeglasses (lenses and frames) or contacts <ul style="list-style-type: none"> <li>• Access to one of Medicare Advantage's largest national networks of vision providers and retail providers</li> <li>• Eyewear available from many online providers, including Warby Parker and GlassesUSA</li> <li>• You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network</li> </ul> | No coverage    |

| Medical benefits                                                                                                                                                          |                                                                                                                            |                                                                  |                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------|
|                                                                                                                                                                           |                                                                                                                            | In-network                                                       | Out-of-network                                                                |
| <b>Mental health</b>                                                                                                                                                      | Inpatient visit <sup>2</sup><br>Our plan covers 90 days for an inpatient hospital stay                                     | \$610 copay per day: days 1-3<br>\$0 copay per day: days 4-90    | Not covered                                                                   |
|                                                                                                                                                                           | Outpatient group therapy visit <sup>2</sup>                                                                                | \$15 copay                                                       | Not covered                                                                   |
|                                                                                                                                                                           | Outpatient individual therapy visit <sup>2</sup>                                                                           | \$25 copay                                                       | Not covered                                                                   |
|                                                                                                                                                                           | Virtual mental health visits                                                                                               | \$0 copay                                                        | Same as an Outpatient mental health office visit                              |
| <b>Skilled nursing facility (SNF)<sup>2</sup></b><br>Our plan covers up to 100 days in a SNF.                                                                             |                                                                                                                            | \$0 copay per day: days 1-20<br>\$221 copay per day: days 21-100 | Not covered                                                                   |
| <b>Outpatient rehabilitation services</b>                                                                                                                                 | Physical therapy and speech and language therapy visit <sup>2</sup>                                                        | \$55 copay                                                       | \$55 copay <sup>‡</sup>                                                       |
|                                                                                                                                                                           | Occupational Therapy Visit <sup>2</sup>                                                                                    | \$35 copay                                                       | Not covered                                                                   |
| <b>Ambulance<sup>2</sup></b><br>Your provider must obtain prior authorization for non-emergency transportation.                                                           |                                                                                                                            | \$350 copay for ground<br>\$350 copay for air                    | Not covered (except for emergencies)                                          |
| <b>Medicare Part B prescription drugs</b><br>In-network cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Chemotherapy drugs <sup>2</sup>                                                                                            | 20% coinsurance                                                  | 20% coinsurance <sup>‡</sup>                                                  |
|                                                                                                                                                                           | Part B covered insulin <sup>2</sup>                                                                                        | 20% coinsurance; up to \$35                                      | 20% coinsurance <sup>‡</sup>                                                  |
|                                                                                                                                                                           | Other Part B drugs <sup>2</sup><br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | \$0 copay for allergy antigens<br>20% coinsurance for all others | \$0 copay for allergy antigens<br>20% coinsurance for all others <sup>‡</sup> |

| Additional plan benefits                                    |                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                        |                              |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
|                                                             |                                                                                                           | In-network                                                                                                                                                                                                                                                                                                                                                             | Out-of-network               |
| <b>Chiropractic services</b>                                | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>2</sup> | \$15 copay                                                                                                                                                                                                                                                                                                                                                             | Not covered                  |
| <b>Diabetes management</b>                                  | Diabetes monitoring supplies <sup>2</sup>                                                                 | \$0 copay<br><br>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.<br><br>Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.<br><br>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Check Aviva Plus. | Not covered                  |
|                                                             | Diabetes self-management training                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                              | Not covered                  |
|                                                             | Therapeutic shoes or inserts <sup>2</sup>                                                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                        | Not covered                  |
| <b>Durable medical equipment (DME) and related supplies</b> | DME (e.g., wheelchairs, oxygen) <sup>2</sup>                                                              | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                        | Not covered                  |
|                                                             | Prosthetics (e.g., braces, artificial limbs) <sup>2</sup>                                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                        | 20% coinsurance <sup>‡</sup> |

| Additional plan benefits                                                                                 |                                                  |                                                                                                                                                                                                                                                                                                                                        |                                                              |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
|                                                                                                          |                                                  | In-network                                                                                                                                                                                                                                                                                                                             | Out-of-network                                               |
|  <b>Fitness program</b> |                                                  | \$0 copay<br>Your fitness program helps you stay active and connected at the gym or in your community. It's available to you at no additional cost and includes: <ul style="list-style-type: none"> <li>• Free gym membership at core locations</li> <li>• Access to a large national network of gyms and fitness locations</li> </ul> | No coverage                                                  |
|                                                                                                          |                                                  |                                                                                                                                                                                                                                                                                                                                        |                                                              |
| <b>Foot care</b><br>(podiatry services)                                                                  | Foot exams and treatment <sup>2</sup>            | \$45 copay                                                                                                                                                                                                                                                                                                                             | Not covered                                                  |
|                                                                                                          | Routine foot care                                | \$45 copay, 6 visits per year                                                                                                                                                                                                                                                                                                          | No coverage                                                  |
| <b>Meal benefit</b>                                                                                      |                                                  | \$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay                                                                                                                                                                                                            | No coverage                                                  |
| <b>Home health care<sup>2</sup></b>                                                                      |                                                  | \$0 copay                                                                                                                                                                                                                                                                                                                              | Not covered                                                  |
| <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                                                                                                                                                                                                                                                                                                                              | Not covered                                                  |
| <b>Outpatient substance use disorder services</b>                                                        | Outpatient group therapy visit <sup>2</sup>      | \$15 copay                                                                                                                                                                                                                                                                                                                             | Not covered                                                  |
|                                                                                                          | Outpatient individual therapy visit <sup>2</sup> | \$25 copay                                                                                                                                                                                                                                                                                                                             | Not covered                                                  |
| <b>Renal dialysis<sup>2</sup></b>                                                                        |                                                  | 20% coinsurance                                                                                                                                                                                                                                                                                                                        | Not covered out-of-network (except in emergency situations). |

<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.

¥ Out-of-network services are limited to CaroMont providers or facilities only in Gaston County

## Member discounts



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

## About this plan

AARP® Medicare Advantage Patriot No Rx NC-MA02 (HMO-POS) 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.

Our service area includes these counties in:

**North Carolina:** Alamance, Alexander, Alleghany, Anson, Ashe, Avery, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Burke, Cabarrus, Caldwell, Camden, Caswell, Catawba, Chatham, Cherokee, Chowan, Clay, Cleveland, Columbus, Craven, Cumberland, Currituck, Dare, Davidson, Davie, Duplin, Durham, Edgecombe, Forsyth, Franklin, Gaston, Gates, Graham, Granville, Greene, Guilford, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Hyde, Iredell, Jackson, Johnston, Jones, Lee, Lenoir, Lincoln, Macon, Madison, Martin, McDowell, Mecklenburg, Mitchell, Montgomery, Moore, Nash, New Hanover, Northampton, Onslow, Orange, Pamlico, Pasquotank, Pender, Perquimans, Person, Pitt, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Rutherford, Sampson, Scotland, Stanly, Stokes, Surry, Swain, Transylvania, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, Yadkin, Yancey.

## Use network providers

AARP® Medicare Advantage Patriot No Rx NC-MA02 (HMO-POS) has a network of doctors, hospitals, and other providers. For some services you can use providers that are not in our network. Out-of-network services are limited to the plan's service area as described on the cover. If you have any questions, please contact customer service. With this plan, you have the freedom to enjoy access to care at in-network costs when you visit any provider participating in the UnitedHealthcare® Medicare National Network (exclusions may apply). 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.

You can go to **[AARPMedicarePlans.com](https://www.aarpmedicareplans.com)** to search for a network provider using the online directory.

## Required Information

AARP® Medicare Advantage Patriot No Rx NC-MA02 (HMO-POS) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. You do not need to be an AARP member to enroll in a Medicare Advantage or Prescription Drug Plan. AARP and its affiliates are not insurers. AARP encourages you to consider your needs when selecting products and does not make specific product recommendations for individuals.

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

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

You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party. Premiums, copays, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

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.

**Hearing aids** - The plan may only cover hearing aids from a UnitedHealthcare Hearing network provider. Other hearing exam providers are available in the UnitedHealthcare network.

**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.

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

**Fitness program** - The fitness benefits and gym networks vary by plan/area and participating locations may change. The fitness benefit includes a standard fitness membership at participating locations. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.

**Member discounts** - As a UnitedHealthcare Medicare Advantage plan member, you'll have access to an exclusive collection of discounts on hundreds of products and services. Once you're a member, you can sign in to your member site for a list of discounts available to you. The discounts described are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process. Discount offerings may vary by plan and are not available on all plans. The discount offers are made available to members through a third party. Participation in these third-party discount offers is subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties.

**Rewards Program** - Medicare Advantage reward offerings may vary by plan and are not available in all plans. By participating in the program or accessing rewards funds, you agree to the **Rewards Program Terms of Service**. Members must participate January through December to earn all available rewards. Rewards must be earned and reported within time frames specified by the plan.