# Summary of Benefits 2027

**UHC Dual Complete GA-S3 (HMO-POS D-SNP)**

H5322-049-003

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

Download the **UnitedHealthcare app**

Visit **UHC.com/CommunityPlan**

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

UnitedHealthcare® Dual Complete

Y0066_SB_H5322_049_003_2027_M

# 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 **myUHCAdvantage.com** or call Customer Service for help. After you enroll in the plan, you will get more information on how to view your plan details online.

## UHC Dual Complete GA-S3 (HMO-POS D-SNP)

| **Medical premium, deductible and limits** | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **Monthly plan premium** | $0<br>You need to continue to pay your Medicare Part B premium | |
| **Annual medical deductible** | Your medical deductible is the Original Medicare Part B deductible amount 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. The 2026 Original Medicare deductible amount is $283. The 2027 amount will be set by CMS in the fall of 2026. Our plan will provide updated rates as soon as they are released. | |
| **Maximum out-of-pocket amount** (does not include prescription drugs or any Medicaid cost-shares) | $9,850<br>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers.<br><br>Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount. | Unlimited out-of-network |
| **Medicare cost-sharing** | If you have full Medicaid benefits, you will pay $0 for your Medicare-covered services unless a separate Medicaid cost-share applies, as noted by the cost-sharing in this chart. | If you have full Medicaid benefits and your provider accepts Medicaid, you will pay $0 for your Medicare-covered services unless a separate Medicaid cost-share applies. Otherwise, you will pay the cost-sharing amount as noted in this chart. |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Inpatient hospital care**[2]<br>Our plan covers an unlimited number of days for an inpatient hospital stay. | | $0 copay per stay, or<br>$1,950 copay per stay | Not covered |
| **Outpatient hospital**<br>Cost-sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC)[2] | $0 copay for a colonoscopy<br>$0 copay or 20% coinsurance otherwise | Not covered |
| | Outpatient hospital, including surgery[2] | $0 copay for a colonoscopy<br>$0 copay or 20% coinsurance otherwise | Not covered |
| | Outpatient hospital observation services[2] | $0 copay or 20% coinsurance | Not covered |
| **Doctor visits** | Primary care provider | $0 copay or 20% coinsurance | Not covered |
| | Specialists[1,2] | $0 copay or 20% coinsurance | Not covered |
| | Virtual medical visits | $0 copay | Same as a Doctor's office visit |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **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 |
| | • Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screening<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings and monitoring<br>• Hepatitis C screening<br>• HIV screening<br>• Lung cancer with low dose computed tomography (LDCT) screening<br>• Medical nutrition therapy services<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screenings and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screenings and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19<br>• "Welcome to Medicare" preventive visit (one-time)<br>Any additional preventive services approved by Medicare during the contract year will be covered.<br>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 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 or $40 copay 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<br>$0 copay or 20% coinsurance otherwise | Not covered |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | Lab services[2] | $0 copay | Not covered |
| | Diagnostic tests and procedures[2] | $0 copay or 20% coinsurance | Not covered |
| | Therapeutic radiology[2] | $0 copay or 20% coinsurance | Not covered |
| | Outpatient X-rays[2] | $0 copay or 20% coinsurance | Not covered |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues[2] | $0 copay or 20% coinsurance | Not covered |
| | Routine hearing exam | $0 copay for a routine hearing exam to help support hearing health | No coverage |
| | Hearing aids[2] | $2,200 allowance for 2 hearing aids every 2 years<br>• A broad selection of high-value and brand name prescription hearing aids<br>• Access to one of the largest national networks of hearing professionals with more than 6,500 locations<br>• 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period<br>• Hearing aids purchased outside of UnitedHealthcare Hearing are not covered. | No coverage |
| **Routine dental benefits** | Preventive and comprehensive services | $2,500 allowance for all covered dental services*<br>$0 copay for covered preventive and comprehensive services like cleanings, fillings, crowns, bridges and dentures<br>• No annual deductible<br>• Access to one of the largest national dental networks<br>• Freedom to see any dentist | |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Vision services** Depending on your Medicaid eligibility, Medicaid may have a separate copay of up to $3 for each visit with an ophthalmol ogist or optometrist. | Exam to diagnose and treat diseases and conditions of the eye[2] | $0 copay | Not covered |
| | Eyewear after cataract surgery | $0 copay | Not covered |
| | Routine eye exam | $0 copay for a routine eye exam each year to help protect your eyesight and health | No coverage |
| | Routine eyewear | $300 allowance every year for 1 pair of eyeglasses (lenses and frames) or contacts<br>• Access to one of Medicare Advantage's largest national networks of vision providers and retail providers<br>• Eyewear available from many online providers, including Warby Parker and GlassesUSA<br>• You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network | No coverage |
| **Mental health** | Inpatient visit[2] Our plan covers 90 days for an inpatient hospital stay | $0 copay per stay, or $1,950 copay per stay | $1,950 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 | Same as an Outpatient mental health office visit |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Skilled nursing facility (SNF)[2]**<br>(Stay must meet Medicare coverage criteria)<br>Our plan covers up to 100 days in a SNF. | | $0 copay per day: days 1-100, or<br>You pay the Original Medicare cost sharing amount for 2027 which will be set by CMS in the fall of 2026. These are the 2026 cost sharing amounts and may change for 2027. Our plan will provide updated rates as soon as they are released.<br>$0 copay per day: days 1-20<br>$217 copay per day: days 21-100 | Not covered |
| **Outpatient rehabilitation services** | Physical therapy and speech and language therapy visit[2] | $0 copay or 20% coinsurance | Not covered |
| | Occupational Therapy Visit[2] | $0 copay or 20% coinsurance | Not covered |
| **Ambulance[2]**<br>Your provider must obtain prior authorization for non-emergency transportation. | | $0 copay or 20% coinsurance for ground<br>$0 copay or 20% coinsurance for air | Not covered (except for emergencies) |
| **Routine transportation** | | $0 copayment for 36 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies | Not covered |
| **Medicare Part B prescription drugs**<br>Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs.<br>Depending on your Medicaid eligibility, Medicaid may have a separate copay of up to $3 for each | Chemotherapy drugs[2] | $0 copay or 20% coinsurance | Not covered |
| | Part B covered insulin[2] | $0 copay or 20% coinsurance; up to $35 | Not covered |
| | Other Part B drugs[2]<br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | $0 copay for allergy antigens<br>$0 copay or 20% coinsurance for all others | Not covered |

| Medical benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| Medicare Part B drug. | | | |

| Prescription drugs | |
|---|---|
| **If you don't qualify for Low-Income Subsidy (LIS), you pay the Medicare Part D cost-share outlined in the Evidence of Coverage. If you do qualify for Low-Income Subsidy (LIS) you pay:** | |
| **Deductible** | Your deductible amount is $0. |
| **Initial Coverage** | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,400, 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, $1.65, or $5.80 copay<br>Drugs that are in Tier 1 and Tier 2 are always $0 copay. (Some covered drugs are limited to a 30-day supply) |
| All other drugs[3] | $0, $5, or $14.40 copay<br>Drugs that are in Tier 1 and Tier 2 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.

*Depending on your Medicaid eligibility, Medicaid may have a separate copay of up to $3 for each Medicare Part D drug.

| Additional plan 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 | Not covered |
| **Diabetes management** | Diabetes monitoring supplies[2] | $0 copay | Not covered |

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| | | 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. | |
| | Diabetes self-management training | $0 copay | Not covered |
| | Therapeutic shoes or inserts[2] | $0 copay or 20% coinsurance | Not covered |
| **Durable medical equipment (DME) and related supplies**<br>Depending on your Medicaid eligibility, Medicaid may have a separate copay of up to $3. | DME (e.g., wheelchairs, oxygen)[2] | $0 copay or 20% coinsurance | Not covered |
| | Prosthetics (e.g., braces, artificial limbs)[2] | $0 copay or 20% coinsurance | Not covered |
|  **Fitness program** | | $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 cost and includes:<br>• Free gym membership at core locations<br>• Access to a large national network of gyms and fitness locations | No coverage |

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network** | **Out-of-network** |
| **Foot care** (podiatry services) | Foot exams and treatment[2] | $0 copay or 20% coinsurance | Not covered |
| | Routine foot care | No coverage | $0 copay, 4 visits per year |
| **Meal benefit** | | $0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay | No coverage |
| **Home health care[2]** Depending on your Medicaid eligibility, Medicaid may have a separate copay of up to $3 per visit. | | $0 copay | Not covered |
| **Hospice** | | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan. | |
| **Opioid treatment program services[2]** | | $0 copay | Not covered |
| **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 |

| Additional plan benefits | | |
|---|---|---|
| | **In-network** | **Out-of-network** |
| **OTC, healthy food, utilities + wellness support**<br>Special Supplemental Benefits for the Chronically Ill (SSBCI) allow eligible members—whose condition is verified by their provider—to use plan credits for healthy food and utilities, along with OTC and other wellness support products. | $141 credit every month for over-the-counter (OTC) products and wellness support, plus healthy food and utilities for qualifying members<br>• Choose from thousands of OTC products, like first aid supplies, pain relievers and more<br>• Buy healthy foods like fruits and vegetables, meat and seafood, dairy products and bottled water<br>• Shop at thousands of participating stores, including Walmart, Walgreens, Dollar General, Target and at neighborhood stores near you<br>• Pay home utilities like electricity, heat, water and internet<br>• Get wellness support including in-home services, weight management counseling, caregiver relief, select fitness items and more | No coverage |
| **Renal dialysis**[2] | $0 copay or 20% coinsurance | Not covered out-of-network (except in emergency situations). |

[1] Requires a referral from your doctor.

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

*Benefits are combined in and out-of-network.

## 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.

## 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 the 2027 Original Medicare Part B deductible amount for covered medical services you receive from providers as described below. The 2026 Medicare deductible amount is $283. The 2027 amount will be set by CMS in the fall of 2026. Our plan will provide updated rates as soon as they are released. 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**<br>List of applicable services | **Out-of-network**<br>List of applicable services |
|---|---|
| **Mental health**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit | **Mental health**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit |
| **Ambulance (All Non-emergency)** | |
| **Outpatient substance use disorder services**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit | **Outpatient substance use disorder services**<br>• Outpatient group therapy visit<br>• Outpatient individual therapy visit |
| **Outpatient hospital**<br>• Ambulatory surgical center (ASC), excluding diagnostic colonoscopy<br>• Outpatient hospital, including surgery, excluding diagnostic colonoscopy<br>• Outpatient hospital observation services | |
| **Doctor visits**<br>• Primary<br>• 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

**Hearing services**

- 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

**Physical therapy and speech and language therapy visit**

**Medicare Part B drugs**

- Chemotherapy drugs
- Other Part B drugs

**Chiropractic services**

- Manual manipulation of the spine to correct subluxation

**Diabetes management**

- Diabetes monitoring supplies
- Therapeutic shoes or inserts

**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

**Occupational therapy visit**

**Opioid treatment program services**

**Renal dialysis**

## 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 Georgia Department of Community Health 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 Georgia Department of Community Health, 1-877-423-4746.

| Benefits | Medicaid | UHC Dual Complete GA-S3 (HMO-POS D-SNP) |
|---|---|---|
| **Inpatient Hospital Care** | Covered | Covered |
| **Doctor Office Visits** | Covered | Covered |
| **Preventive Care** | Covered | Covered |
| **Emergency Care** | Covered | Covered |
| **Urgently Needed Services** | Covered | Covered |
| **Diagnostic Tests Lab and Radiology Services and X-Rays** | Covered With Limitations | Covered |
| **Hearing Services** | Covered With Limitations | Covered |
| **Dental Services** | Covered With Limitations | Covered |
| **Vision Services** | Covered With Limitations | Covered |
| **Inpatient Mental Health Care** | Covered With Limitations | Covered |
| **Mental Health Care** | Covered With Limitations | Covered |
| **Skilled Nursing Facility (SNF)** | Covered | Covered |
| **Ambulance** | Covered | Covered |
| **Transportation (Routine)** | Covered | Covered |
| **Prescription Drug Benefits** | Covered | Covered |
| **Chiropractic Care** | Not Covered | Covered with limitations |
| **Diabetes Supplies and Services** | Covered | Covered |
| **Durable Medical Equipment** | Covered With Limitations | Covered |
| **Foot Care** | Covered With Limitations | Covered |
| **Home Health Care** | Covered | Covered |
| **Hospice** | Covered | Covered |
| **Outpatient Hospital Services** | Covered | Covered |
| **Renal Dialysis** | Covered | Covered |
| **Prosthetic Devices** | Covered | Covered |

## About this plan

UHC Dual Complete GA-S3 (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. 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 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.
- **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 these counties in:

Georgia: Floyd, Haralson, Paulding, Polk.

## Use network providers and pharmacies

UHC Dual Complete GA-S3 (HMO-POS D-SNP) has a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network. 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. This health plan requires you to select a primary care provider (PCP) from the network. Your PCP can handle most routine health care needs and will be responsible to coordinate your care. If you need to see a network specialist or other network provider, you may need to get a referral from your PCP. We encourage you to find out which specialists and hospitals your PCP would recommend for you and would refer you to for care, prior to selecting them as your plan's PCP. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **UHC.com/CommunityPlan** 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 GA-S3 (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.

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.

**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 available only 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, who also meet plan criteria indicating they are at high risk for hospitalization and eligible for intensive care coordination. There may be other qualifying chronic conditions not listed. If you use this benefit for certain utilities, it may be considered income for housing assistance. Check with your housing authority for details.

**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.