



# Summary of Benefits 2026

**UHC Complete Care Support DE-5A (HMO-POS C-SNP)**  
H5253-200-000

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



**UHC.com/Medicare**



**Toll-free 1-866-367-7527, TTY 711**  
8 a.m.-8 p.m. local time, 7 days a week

# Summary of Benefits

January 1, 2026 - December 31, 2026

This is a summary of what we cover and what you pay. For a complete list of covered services, limitations and exclusions, review the Evidence of Coverage (EOC) at [myUHCMedicare.com](https://myUHCMedicare.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 Complete Care Support DE-5A (HMO-POS C-SNP)

| Medical premium, deductible and limits                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Monthly plan premium                                                                                                | \$31.20                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Annual medical deductible                                                                                           | Your medical deductible is the Original Medicare Part B deductible amount in-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 2025 deductible amount is \$257. The 2026 amount will be set by CMS in the fall of 2025. Our plan will provide updated rates as soon as they are released. |
| Maximum out-of-pocket amount (does not include prescription drugs)                                                  | <p>\$9,250</p> <p>This is the most you will pay out-of-pocket each year for Medicare-covered services and supplies received from network providers.</p> <p>If you reach this amount, you will still need to pay your monthly premiums. Out-of-pocket costs paid for your Part D prescription drugs are not included in this amount.</p>                                                                                       |
| Medicare cost-sharing                                                                                               | If you have full Medicaid benefits or are a Qualified Medicare Beneficiary (QMB), you will pay \$0 for your Medicare-covered services as noted by the cost-sharing in this chart.                                                                                                                                                                                                                                             |
| Medical benefits                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Inpatient hospital care <sup>2</sup><br>Our plan covers an unlimited number of days for an inpatient hospital stay. | Depending upon your level of Medicaid eligibility, you pay \$0 copay per stay, or \$1,885 copay per stay                                                                                                                                                                                                                                                                                                                      |

## Medical benefits

### Outpatient hospital

Cost-sharing for additional plan covered services will apply.

Ambulatory surgical center (ASC)<sup>2</sup>

\$0 copay for a colonoscopy  
Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance otherwise

Outpatient hospital, including surgery<sup>2</sup>

\$0 copay for a colonoscopy  
Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance otherwise

Outpatient hospital observation services<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

### Doctor visits

Primary care provider

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Specialists<sup>1,2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Virtual medical visits

\$0 copay to talk with a network telehealth provider online through live audio and video

### Preventive services

Routine physical

\$0 copay, 1 per year

Medicare-covered

\$0 copay

- |                                                                                                                      |                                                                                         |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Abdominal aortic aneurysm screening                                                         | <input type="checkbox"/> Hepatitis C screening                                          |
| <input type="checkbox"/> Alcohol misuse counseling                                                                   | <input type="checkbox"/> HIV screening                                                  |
| <input type="checkbox"/> Annual wellness visit                                                                       | <input type="checkbox"/> Lung cancer with low dose computed tomography (LDCT) screening |
| <input type="checkbox"/> Bone mass measurement                                                                       | <input type="checkbox"/> Medical nutrition therapy services                             |
| <input type="checkbox"/> Breast cancer screening (mammogram)                                                         | <input type="checkbox"/> Medicare Diabetes Prevention Program (MDPP)                    |
| <input type="checkbox"/> Cardiovascular disease (behavioral therapy)                                                 | <input type="checkbox"/> Obesity screenings and counseling                              |
| <input type="checkbox"/> Cardiovascular screening                                                                    | <input type="checkbox"/> Prostate cancer screenings (PSA)                               |
| <input type="checkbox"/> Cervical and vaginal cancer screening                                                       | <input type="checkbox"/> Sexually transmitted infections screenings and counseling      |
| <input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) | <input type="checkbox"/> Tobacco use cessation counseling (counseling for               |
| <input type="checkbox"/> Depression screening                                                                        |                                                                                         |
| <input type="checkbox"/> Diabetes screenings and monitoring                                                          |                                                                                         |

## Medical benefits

- people with no sign of tobacco-related disease)
- ☐ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19
- ☐ “Welcome to Medicare” preventive visit (one-time)

Any additional preventive services approved by Medicare during the contract year will be covered.

This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers.

### Emergency care

Depending on your level of Medicaid eligibility, \$0 copay or \$115 copay (\$0 copay for emergency care outside the United States) per visit. If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency Care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.

### Urgently needed services

Depending on your level of Medicaid eligibility, \$0 copay or \$40 copay (\$0 copay for urgently needed services outside the United States) per visit

### Diagnostic tests, lab and radiology services, and X-rays

Diagnostic radiology services (e.g. MRI, CT scan)<sup>2</sup>

\$0 copay for each diagnostic mammogram  
Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance otherwise

Lab services<sup>2</sup>

\$0 copay

Diagnostic tests and procedures<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Therapeutic radiology<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Outpatient X-rays<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance



### Hearing services

Exam to diagnose and treat hearing and balance issues<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Routine hearing exam

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

Hearing aids<sup>2</sup>

\$2,200 allowance for 2 hearing aids every 2 years

## Medical benefits

|                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                       |                                                                            | <ul style="list-style-type: none"> <li><input type="checkbox"/> A broad selection of over-the-counter (OTC), high-value and brand-name prescription hearing aids</li> <li><input type="checkbox"/> Access to one of the largest national networks of hearing professionals with more than 6,500 locations</li> <li><input type="checkbox"/> 3-year manufacturer warranty on all prescription hearing aids covers a trial period and damage or repair during warranty period</li> <li><input type="checkbox"/> Hearing aids purchased outside of UnitedHealthcare Hearing are not covered</li> </ul>                                                                                                      |
|  <b>Routine dental benefits</b><br><br>Covered in and out-of-network | Preventive and comprehensive services <sup>2</sup>                         | \$2,500 allowance for all covered dental services*<br><br>\$0 copay for covered preventive and comprehensive services like cleanings, fillings, crowns, bridges and dentures <ul style="list-style-type: none"> <li><input type="checkbox"/> No annual deductible</li> <li><input type="checkbox"/> Access to one of the largest national dental networks</li> <li><input type="checkbox"/> Freedom to see any dentist</li> </ul>                                                                                                                                                                                                                                                                        |
|  <b>Vision services</b>                                            | Exam to diagnose and treat diseases and conditions of the eye <sup>2</sup> | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                       | Eyewear after cataract surgery                                             | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                       | Routine eye exam                                                           | \$0 copay for a routine eye exam each year to help protect your eyesight and health                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                       | Routine eyewear                                                            | \$250 allowance every year for 1 pair of frames or contacts <ul style="list-style-type: none"> <li><input type="checkbox"/> Free standard prescription lenses including single vision, bifocals, trifocals and Tier I (standard) progressives — all with scratch-resistant coating</li> <li><input type="checkbox"/> Access to one of Medicare Advantage's largest national networks of vision providers and retail providers</li> <li><input type="checkbox"/> Eyewear available from many online providers, including Warby Parker and GlassesUSA</li> <li><input type="checkbox"/> You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network</li> </ul> |

## Medical benefits

### Mental health

Inpatient visit<sup>2</sup>  
Our plan covers  
90 days for an  
inpatient hospital  
stay

Depending upon your level of Medicaid eligibility, you pay \$0 copay per stay, or \$1,885 copay per stay

Outpatient group  
therapy visit<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Outpatient  
individual therapy  
visit<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Virtual mental  
health visits

\$0 copay to talk with a network telehealth provider online through live audio and video

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

(Stay must meet Medicare coverage criteria)

Our plan covers up to 100 days in a SNF.

Depending upon your level of Medicaid eligibility, you pay \$0 copay per day: days 1-100, or You pay the Original Medicare cost sharing amount for 2026 which will be set by CMS in the fall of 2025. These are 2025 cost sharing amounts and may change for 2026. Our plan will provide updated rates as soon as they are released.  
\$0 copay per day: days 1-20  
\$209.50 copay per day: days 21-100

### Outpatient rehabilitation services

Physical therapy  
and speech and  
language therapy  
visit<sup>1,2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Occupational  
Therapy Visit<sup>1,2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

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

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

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance for ground  
Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance for air

### Routine transportation

\$0 copay for 36 one-way trips to or from approved locations, such as medically related appointments, gyms and pharmacies

## Medical benefits

|                                                                                                                   |                                                                                         |                                                                                              |
|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <b>Medicare Part B prescription drugs</b>                                                                         | Chemotherapy drugs <sup>2</sup>                                                         | Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance                |
| Cost sharing shown is the maximum you will pay for Part B prescription drugs. You may pay less for certain drugs. | Part B covered insulin <sup>2</sup>                                                     | Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance, up to \$35    |
|                                                                                                                   | Other Part B drugs <sup>2</sup>                                                         | \$0 copay for allergy antigens                                                               |
|                                                                                                                   | Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance for all others |

## What is coinsurance?

Coinsurance is a portion or part of the total cost, typically as a percentage. For example, if your coinsurance is 25% and the total cost of your prescription is \$100, you would pay \$25. The plan pays the rest. You pay the full cost of your drugs until you meet the deductible, then you'll start paying the coinsurance amount.

## Prescription drug payment stages if you qualify for Low-Income Subsidy (LIS)

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

<sup>^</sup>Members living in long-term care facilities pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

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

## Prescription drug payment stages if you do not qualify for LIS

| <b>Deductible</b>                    | Your plan has a \$615 prescription drug deductible. You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage.                                                                                            |                                                                        |                                                                        |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------|
| <b>Initial Coverage</b>              | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,100, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. |                                                                        |                                                                        |
| <b>Drug Coverage</b>                 | <b>Retail</b>                                                                                                                                                                                                                                                           | <b>Mail Order</b>                                                      |                                                                        |
|                                      | <b>30-day supply<sup>^</sup></b>                                                                                                                                                                                                                                        | <b>100-day supply</b>                                                  | <b>100-day supply</b>                                                  |
| <b>All covered drugs<sup>3</sup></b> | 25% coinsurance                                                                                                                                                                                                                                                         | 25% coinsurance<br>(Some covered drugs are limited to a 30-day supply) | 25% coinsurance<br>(Some covered drugs are limited to a 30-day supply) |
| <b>Catastrophic Coverage</b>         | Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.                                                                                                                                                 |                                                                        |                                                                        |

<sup>^</sup>Members living in long-term care facilities pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

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

## Additional benefits

|                              |                                                                                                           |                                                                                                                                                                                                                                                                           |
|------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Chiropractic services</b> | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>2</sup> | Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance                                                                                                                                                                                             |
| <b>Diabetes management</b>   | Diabetes monitoring supplies <sup>2</sup>                                                                 | <p>\$0 copay</p> <p>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.</p> <p>Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.</p> |

## Additional benefits

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

Diabetes self-management training

\$0 copay

Therapeutic shoes or inserts<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

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

DME (e.g., wheelchairs, oxygen)<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Prosthetics (e.g., braces, artificial limbs)<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance



### Fitness program

\$0 copay

Your fitness program helps you stay active and connected at the gym, from home or in your community. It's available to you at no additional cost and includes:

- ☐ Free gym membership at core and premium locations
- ☐ Access to a large national network of gyms and fitness locations
- ☐ On-demand workout videos and live streaming fitness classes
- ☐ Online memory fitness activities

### Foot care (podiatry services)

Foot exams and treatment<sup>2</sup>

\$0 copay

Routine foot care

\$0 copay, 4 visits per year

### Meal benefit<sup>2</sup>

\$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay

### Home health care<sup>2</sup>

\$0 copay

### Hospice

You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.

### Opioid treatment program services<sup>2</sup>

\$0 copay

## Additional benefits

### Outpatient substance use disorder services

Outpatient group therapy visit<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

Outpatient individual therapy visit<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance



### OTC and food credit

\$181 credit every month for over-the-counter (OTC) products, plus healthy food for qualifying members

- ☐ Choose from thousands of OTC products, like first aid supplies, pain relievers and more
- ☐ Buy healthy foods like fruits, vegetables, meat, seafood, dairy products and water
- ☐ Shop at thousands of participating stores, including Walmart, Walgreens and Dollar General, or at neighborhood stores near you

### Renal dialysis<sup>2</sup>

Depending on your level of Medicaid eligibility, \$0 copay or 20% coinsurance

<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

## 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 2026 Original Medicare Part B deductible amount for covered medical services you receive from providers as described below. The 2025 Medicare deductible amount is \$257. The 2026 amount will be set by CMS in the fall of 2025. 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-network to the following Medicare-covered benefit categories, unless otherwise specified:

## In-network

List of applicable services

### Outpatient hospital

- ☐ Ambulatory surgical center (ASC), excluding diagnostic colonoscopy
- ☐ Outpatient hospital, including surgery, excluding diagnostic colonoscopy
- ☐ Outpatient hospital observation services

### Doctor visits

- ☐ Primary
- ☐ Specialists

### Diagnostic tests, lab and radiology services, and X-rays

- ☐ Diagnostic radiology services (e.g. MRI), excluding diagnostic mammogram and in-home vascular screening
- ☐ Lab services
- ☐ Diagnostic tests and procedures
- ☐ Therapeutic radiology
- ☐ Outpatient X-rays

### 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
- 

#### **Mental health**

- ☐ Outpatient group therapy visit
  - ☐ Outpatient individual therapy visit
- 

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

---

#### **Ambulance**

---

#### **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 (podiatry services)**

- ☐ Foot exams and treatment
- 

#### **Occupational therapy visit**

---

#### **Opioid treatment program services**

---

#### **Outpatient substance use disorder services**

- ☐ Outpatient group therapy visit
  - ☐ Outpatient individual therapy visit
- 

#### **Renal dialysis**

---

## About this plan

UHC Complete Care Support DE-5A (HMO-POS C-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.

UHC Complete Care Support DE-5A (HMO-POS C-SNP) is a Chronic or Disabling Condition Special Needs Plan designed to specifically help people who have one or more of the following conditions: Cardiovascular Disorders, Chronic Heart Failure, and Diabetes.

Our service area includes these counties in:

**Delaware:** Kent, New Castle, Sussex.

## Use network providers and pharmacies

UHC Complete Care Support DE-5A (HMO-POS C-SNP) has a network of doctors, hospitals, pharmacies and other providers. For routine dental services, you can use providers that are not in our network. This health plan requires you to select a primary care provider (PCP) from the network. Your PCP can handle most routine health care needs and will be responsible to coordinate your care. If you need to see a network specialist or other network provider, you may need to get a referral from your PCP. We encourage you to find out which specialists and hospitals your PCP would recommend for you and would refer you to for care, prior to selecting them as your plan's PCP. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **[UHC.com/Medicare](https://UHC.com/Medicare)** 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 Complete Care Support DE-5A (HMO-POS C-SNP) 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.

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

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [medicare.gov](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-800-711-0646 for additional information (TTY users should call 711). Hours are 7 a.m.-10 p.m. CT: 7 Days Oct-Mar; M-F Apr-Sept.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, letra grande, audio o bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-800-711-0646, para obtener información adicional (los usuarios de TTY deben comunicarse al 711). Los horarios de atención son de 7 a.m. a 10 p.m. hora del Centro: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

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

### Hearing aids

Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider. Provider network size may vary by local market. OTC hearing aid warranties, if available, will vary by device and are handled through the manufacturer. One-time professional fee may apply for prescription hearing aids.

### Routine dental benefits

If your plan offers out-of-network dental coverage and you see an out-of-network dentist, you might be billed more. Provider network may vary in local market. Dental network size based on Zelis Network360, May 2023.

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

### OTC and food credit

OTC and food benefits have expiration timeframes. Review your Evidence of Coverage (EOC) for more information. The healthy food benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as diabetes, chronic heart failure and/or cardiovascular disorders, and who also meet all applicable plan coverage criteria.

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

**Rewards Program**

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