



# Summary of Benefits 2026

**UHC Complete Care AL-5 (HMO-POS C-SNP)**  
H0432-017-000

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

**United  
Healthcare®**

# 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 AL-5 (HMO-POS C-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                                                                                           |                                                     | This plan does not have a medical deductible.                                                                                                                                                                                                        |                                                                                            |
| Maximum out-of-pocket amount (does not include prescription drugs)                                                  |                                                     | \$5,900<br><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. |                                                                                            |
|                                                                                                                     |                                                     |                                                                                                                                                                                                                                                      |                                                                                            |
| Medical benefits                                                                                                    |                                                     |                                                                                                                                                                                                                                                      |                                                                                            |
|                                                                                                                     |                                                     | In-network                                                                                                                                                                                                                                           | Out-of-network                                                                             |
| Inpatient hospital care <sup>2</sup><br>Our plan covers an unlimited number of days for an inpatient hospital stay. |                                                     | \$455 copay per day: days 1-6<br>\$0 copay per day: days 7 and beyond                                                                                                                                                                                | \$455 copay per day: for days 1-6<br>\$0 copay per day: for days 7 and beyond <sup>¥</sup> |
| Outpatient hospital<br>Cost-sharing for additional plan covered services will apply.                                | Ambulatory surgical center (ASC) <sup>2</sup>       | \$0 copay for a colonoscopy<br>\$405 copay otherwise                                                                                                                                                                                                 | Not covered                                                                                |
|                                                                                                                     | Outpatient hospital, including surgery <sup>2</sup> | \$0 copay for a colonoscopy<br>\$455 copay otherwise                                                                                                                                                                                                 | \$0 copay for a colonoscopy<br>\$455 copay otherwise <sup>¥</sup>                          |

| Medical benefits                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                      |
|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|
|                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | In-network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Out-of-network                       |
|                                                                                                   | Outpatient hospital observation services <sup>2</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$455 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$455 copay <sup>‡</sup>             |
| Doctor visits                                                                                     | Primary care provider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$0 copay <sup>‡</sup>               |
|                                                                                                   | Specialists <sup>1,2</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$30 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$30 copay <sup>‡</sup>              |
|                                                                                                   | 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*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$0 copay, 1 per year <sup>**‡</sup> |
|                                                                                                   | Medicare-covered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$0 copay <sup>‡</sup>               |
|                                                                                                   | <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></ul> | <ul style="list-style-type: none"><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> |                                      |
| Any additional preventive services approved by Medicare during the contract year will be covered. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                      |

| Medical benefits                                                                                                 |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                               |
|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
|                                                                                                                  |                                                                    | In-network                                                                                                                                                                                                                                                                                                                                                                                                                      | Out-of-network                                                                |
| This plan covers preventive care screenings and annual physical exams at 100% when you use in-network providers. |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                               |
| <b>Emergency care</b>                                                                                            |                                                                    | \$130 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.                                                                                                                                       |                                                                               |
| <b>Urgently needed services</b>                                                                                  |                                                                    | \$50 copay (\$0 copay for urgently needed services outside the United States) per visit                                                                                                                                                                                                                                                                                                                                         |                                                                               |
| <b>Diagnostic tests, lab and radiology services, and X-rays</b>                                                  | Diagnostic radiology services (e.g. MRI, CT scan) <sup>2</sup>     | \$0 copay for each diagnostic mammogram<br>\$260 copay otherwise                                                                                                                                                                                                                                                                                                                                                                | \$0 copay for each diagnostic mammogram<br>\$260 copay otherwise <sup>¥</sup> |
|                                                                                                                  | Lab services <sup>2</sup>                                          | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                       | \$0 copay <sup>¥</sup>                                                        |
|                                                                                                                  | Diagnostic tests and procedures <sup>2</sup>                       | \$50 copay                                                                                                                                                                                                                                                                                                                                                                                                                      | \$50 copay <sup>¥</sup>                                                       |
|                                                                                                                  | Therapeutic radiology <sup>2</sup>                                 | 20% coinsurance                                                                                                                                                                                                                                                                                                                                                                                                                 | 20% coinsurance <sup>¥</sup>                                                  |
|                                                                                                                  | Outpatient X-rays <sup>2</sup>                                     | \$25 copay                                                                                                                                                                                                                                                                                                                                                                                                                      | \$25 copay <sup>¥</sup>                                                       |
|                                                                                                                  |                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                               |
|  <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                                                                                                                                                                                                                                                                                                                                                             | Not covered                                                                   |
|                                                                                                                  | Hearing aids <sup>2</sup>                                          | \$199 - \$829 copay for each OTC hearing aid. \$199 - \$1,249 copay for each prescription hearing aid. You can purchase up to 2 hearing aids every year. <ul style="list-style-type: none"> <li>• A broad selection of over-the-counter (OTC), 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> </ul> |                                                                               |

## Medical benefits

|                                                                                                                  |                                                                            | In-network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Out-of-network |
|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
|  <b>Routine dental benefits</b> |                                                                            | <ul style="list-style-type: none"> <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>                                                                                                                                                                                                                  |                |
|                                                                                                                  | Preventive services                                                        | \$0 copay for covered preventive services like oral exams, X-rays, routine cleanings and fluoride: * <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>                                                                                                                                                                                                       |                |
|                                                                                                                  | Optional Dental Rider                                                      | For an extra \$44 per month, you'll get access to dental coverage that includes: <ul style="list-style-type: none"> <li>• \$1,500 per year for covered dental services through the Platinum Dental Rider*</li> <li>• \$0 copay for covered network preventive services such as exams, routine cleanings, X-rays and fluoride</li> <li>• 50% coinsurance for all covered network comprehensive services such as fillings, crowns, root canals, dentures, bridges and extractions</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                                                                                                                                                                                                                                                                                                                                                                                                        | Not covered    |

| Medical benefits                                                                              |                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                         |
|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|                                                                                               |                                                                                        | In-network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Out-of-network          |
|                                                                                               | Routine eyewear                                                                        | \$250 allowance every 2 years for 1 pair of frames or contacts <ul style="list-style-type: none"> <li>• Free standard prescription lenses including single vision, bifocals, trifocals and Tier I (standard) progressives</li> <li>• Other covered lenses available with copays from \$40 – \$153</li> <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> |                         |
| Mental health                                                                                 | Inpatient visit <sup>2</sup><br>Our plan covers 90 days for an inpatient hospital stay | \$455 copay per day: days 1-5<br>\$0 copay per day: days 6-90                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 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 to talk with a network telehealth provider online through live audio and video                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |
| <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>\$218 copay per day: days 21-100                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Not covered             |
| Outpatient rehabilitation services                                                            | Physical therapy and speech and language therapy visit <sup>1,2</sup>                  | \$30 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$30 copay <sup>¥</sup> |
|                                                                                               | Occupational Therapy Visit <sup>1,2</sup>                                              | \$30 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$30 copay <sup>¥</sup> |

| Medical benefits                                                                                                                                                          |                                                                                                                            |                                                                  |                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------|
|                                                                                                                                                                           |                                                                                                                            | In-network                                                       | Out-of-network                                                                |
| <b>Ambulance<sup>2</sup></b><br>Your provider must obtain prior authorization for non-emergency transportation.                                                           |                                                                                                                            | \$290 copay for ground<br>\$290 copay for air                    | Not covered (except for emergencies)                                          |
| <b>Routine transportation</b>                                                                                                                                             |                                                                                                                            | Not covered                                                      | Not covered                                                                   |
| <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> |

## What is coinsurance?

Coinsurance is a portion or part of the total cost, typically as a percentage. With this plan, you pay part of the cost of Tier 3, Tier 4 and Tier 5 drugs. 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 |                                                                                                                                                                                                                                                                                                                            |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Deductible</b>                | There is no deductible for drugs in Tier 1 and 2. Your coverage for these drugs starts in the Initial Coverage stage.<br>There is a \$440 deductible for drugs in Tier 3, 4 and 5. You pay the full cost for your drugs in these tiers 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.                                                    |

| Prescription drug payment stages                                                                                   |                                                                                                                                                                                                                                                |                       |                       |
|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| Tier drug coverage                                                                                                 | Retail                                                                                                                                                                                                                                         | Mail Order            |                       |
|                                                                                                                    | 30-day supply^                                                                                                                                                                                                                                 | 100-day supply        | 100-day supply        |
| <b>Tier 1:</b><br>Preferred Generic                                                                                | \$0 copay                                                                                                                                                                                                                                      | \$0 copay             | \$0 copay             |
| <b>Tier 2:</b><br>Generic <sup>3</sup>                                                                             | \$0 copay                                                                                                                                                                                                                                      | \$0 copay             | \$0 copay             |
| <b>Tier 3:</b><br>Preferred Brand                                                                                  | 23% coinsurance                                                                                                                                                                                                                                | 23% coinsurance       | 23% coinsurance       |
| Covered Insulin <sup>4</sup>                                                                                       | 23%, up to \$25 copay                                                                                                                                                                                                                          | 23%, up to \$75 copay | 23%, up to \$75 copay |
| <b>Tier 4:</b><br>Non-Preferred Drug <sup>5</sup>                                                                  | 47% coinsurance                                                                                                                                                                                                                                | N/A                   | N/A                   |
| <b>Tier 5:</b><br>Specialty Tier <sup>5</sup>                                                                      | 28% coinsurance                                                                                                                                                                                                                                | N/A                   | N/A                   |
| <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.                                                                                                                        |                       |                       |
| <b>Additional covered drugs</b><br>These drugs are not covered by Medicare Part D and not on the plan's Drug List. | This plan covers these additional drugs as Tier 2 medications. <ul style="list-style-type: none"> <li>•Vitamin D (50,000)</li> <li>•Sildenafil (generic Viagra)</li> <li>•Cyanocobalamin (Vitamin B-12)</li> <li>•Folic Acid (1 mg)</li> </ul> |                       |                       |

^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> Tier includes enhanced drug coverage.

<sup>4</sup> You pay no more than 23% of the total drug cost or a \$25 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.

<sup>5</sup> Limited to a 30-day supply



| Additional 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-Chek Aviva Plus. | Not covered    |
|                                                             | Diabetes self-management training                                                                         | \$0 copay                                                                                                                                                                                                                                                                                                                                                             | Not covered    |
|                                                             | Therapeutic shoes or inserts <sup>2</sup>                                                                 | \$0 copay                                                                                                                                                                                                                                                                                                                                                             | 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                                                                                                                                                                                                                                                                                                                                                       | Not covered    |

| Additional 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, from home 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> <li>• On-demand workout videos and live streaming fitness classes</li> <li>• Online memory fitness activities</li> </ul> |                |
|                                                                                                          |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                |
| <b>Foot care</b><br>(podiatry services)                                                                  | Foot exams and treatment <sup>2</sup>            | \$30 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Not covered    |
|                                                                                                          | Routine foot care                                | \$30 copay, 6 visits per year                                                                                                                                                                                                                                                                                                                                                                                                                                        | Not covered    |
| <b>Meal benefit<sup>2</sup></b>                                                                          |                                                  | \$0 copay for 28 home-delivered meals immediately after an inpatient hospitalization or skilled nursing facility (SNF) stay                                                                                                                                                                                                                                                                                                                                          |                |
| <b>Home health care<sup>2</sup></b>                                                                      |                                                  | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 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    |

## Additional benefits

|                                                                                                              | In-network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Out-of-network                                               |
|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
|  <b>OTC and food credit</b> | <p>\$55 credit every month for over-the-counter (OTC) products, plus healthy food for qualifying members</p> <ul style="list-style-type: none"><li>• Choose from thousands of OTC products, like first aid supplies, pain relievers and more</li><li>• Buy healthy foods like fruits, vegetables, meat, seafood, dairy products and water</li><li>• Shop at thousands of participating stores, including Walmart, Walgreens and Dollar General, or at neighborhood stores near you</li></ul> |                                                              |
| <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 Southeast Health providers or facilities only in Houston, Dale, and Henry counties

## Optional supplemental benefits

### Platinum Dental Rider premium

Additional \$44 per month

The Platinum Dental Rider includes preventive and comprehensive dental benefits. It can be purchased to replace any dental benefits that may already be offered within your Medicare Advantage Plan.

## 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.

## About this plan

UHC Complete Care AL-5 (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 AL-5 (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:

**Alabama:** Autauga, Baldwin, Barbour, Bibb, Blount, Bullock, Butler, Calhoun, Chambers, Cherokee, Chilton, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Conecuh, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, DeKalb, Elmore, Escambia, Etowah, Fayette, Franklin, Geneva, Greene, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Randolph, Russell, Shelby, St. Clair, Sumter, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox, Winston.

## Use network providers and pharmacies

UHC Complete Care AL-5 (HMO-POS C-SNP) has a network of doctors, hospitals, pharmacies 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. 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 AL-5 (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 1-877-370-4874 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 1-877-370-4874, 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.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

Additional authorizations may be required to access discount programs. 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 services are 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**

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