univera HEALTHCARE

# 2026 SUMMARY OF BENEFITS
## January 1, 2026 – December 31, 2026

## Univera SeniorChoice® Extra (HMO) (H3351-020)
## Univera SeniorChoice® Basic (HMO) (H3351-017)
## Univera SeniorChoice® Advanced (HMO-POS) (H3351-019)

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage. (EOC)" You can also see the Evidence of Coverage on our website medicare.univerahealthcare.com.

### Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Univera SeniorChoice Extra (HMO), Univera SeniorChoice Basic (HMO), and Univera SeniorChoice Advanced (HMO-POS)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov.
- 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 or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

### Sections in this booklet

- Things to know about **Univera SeniorChoice Extra (HMO), Univera SeniorChoice Basic (HMO), and Univera SeniorChoice Advanced (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much you pay for covered services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Additional Benefits

This document is available in other formats such as Braille and large print.

### Things to know about Univera SeniorChoice Extra (HMO), Univera SeniorChoice Basic (HMO), and Univera SeniorChoice Advanced (HMO-POS)

### Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8:00 a.m. to 8:00 p.m., 7 days a week
- From April 1 to September 30, we're open 8:00 a.m. to 8:00 p.m., Monday through Friday
- If you are a member of one of these plans, call toll-free at 1-877-883-9577 (TTY 711).
- If you are not a member of one of these plans, call toll-free at 1-800-659-1986 (TTY 711).
- Our website: medicare.univerahealthcare.com.

## Who can join?

To join **Univera SeniorChoice Extra (HMO), Univera SeniorChoice Basic (HMO), or Univera SeniorChoice Advanced (HMO-POS)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in New York: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming.

## Which doctors, hospitals, and pharmacies can I use?

**Univera SeniorChoice Extra (HMO), Univera SeniorChoice Basic (HMO), and Univera SeniorChoice Advanced (HMO-POS)** have a network of doctors, hospitals, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can use providers that are not in our network.

**Univera SeniorChoice Extra (HMO), Univera SeniorChoice Basic (HMO), and Univera SeniorChoice Advanced (HMO-POS)** also have a network of pharmacies. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider/pharmacy directory at our website at **medicare.univerahealthcare.com**. Or call us and we will send you a copy of the directory.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **medicare.univerahealthcare.com**. Or call us and we will send you a copy of our formulary.

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Univera Healthcare contracts with the Federal Government and is an HMO plan with a Medicare contract. Enrollment in Univera Healthcare depends on contract renewal.

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

Convey is an independent company offering OTC benefits in the Univera Healthcare service area.

TruHearing® is an independent company offering a network of audiologists and hearing aid providers.

The Silver&Fit® Program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). ASH is an independent company. Silver&Fit is a trademark of ASH and used with permission herein.

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Monthly Premium, Deductible, and Limits on How Much you pay for covered services** | | | | |
| **Monthly Plan Premium** | You pay $0 per month. | You pay $0 per month. | You pay $50.80 per month. | You must continue to pay your Medicare Part B premium. |
| **Part B Premium Reduction** | $44.10 reduction of the monthly premium you pay to the Social Security Administration. | Not applicable. | Not applicable. | |
| **Deductible** There is no medical deductible. | $615 per year for prescription drugs on Tiers 2, 3, 4 and 5. | $615 per year for prescription drugs on Tiers 2, 3, 4 and 5. | $300 per year for prescription drugs on Tiers 3, 4 and 5. | You must pay your deductible before the plan will contribute to the costs of your prescriptions. |
| **Maximum Out-of-Pocket Responsibility** Does not include prescription drugs. | $8,500 for medical services you receive from In-Network providers. | $8,500 for medical services you receive from In-Network providers. | $7,500 for medical services you receive from In-Network providers. | The most you pay in copayments/ coinsurance for medical services for the year. |
| **Covered Medical and Hospital Benefits** | | | | |
| **Inpatient Hospital Coverage** | You pay $400 copayment per day, days 1 to 5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. | You pay $390 copayment per day, days 1 to 5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. | **In-Network:** You pay $360 copayment per day, days 1 to 5. You pay $0 copayment for additional Medicare-covered days during your hospital admission.<br><br>**Out-of-Network:** You pay 30% coinsurance. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization is required. Our plan covers an unlimited number of days for an inpatient hospital stay. Benefit applied per admission. |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Outpatient Hospital Coverage** | You pay $400 copayment. | You pay $375 copayment. | **In-Network:** You pay $330 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization is required. |
| **Ambulatory Surgery Center** | You pay $400 copayment. | You pay $375 copayment. | **In-Network:** You pay $330 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization is required. |
| **Doctor Visits Primary** | You pay $5 copayment. | You pay $5 copayment. | **In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| **Doctor Visits Specialists** | You pay $45 copayment. | You pay $30 copayment. | **In-Network:** You pay $30 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Preventive Care** See the Evidence of Coverage for a list of covered preventive services. | You pay $0 copayment. | You pay $0 copayment. | **In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | If you are treated for a new or existing medical condition during a visit where a preventive screening is performed, an office visit copayment will apply to the care received for the new or existing medical condition. Additional preventive services approved by Medicare during the contract year will be covered. |
| **Emergency Care** | You pay $115 copayment. | You pay $115 copayment. | You pay $115 copayment. | If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.<br>Covered Worldwide. |
| **Urgently Needed Services** | You pay $40 copayment. | You pay $40 copayment. | You pay $40 copayment. | Covered worldwide. |
| **Diagnostic Services/Labs/ Imaging** Diagnostic Radiology Service (e.g., MRI, CT scans) | You pay $325 copayment. | You pay $200 copayment. | **In-Network:** You pay $225 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization is required for some services. Contact us for more information. |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Diagnostic Services/Labs/ Imaging (continued)**<br>Lab Services - Diagnostics | You pay $15 copayment. | You pay $0 copayment. | **In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| Diagnostic Tests and Procedures | You pay $15 copayment. | You pay $0 copayment. | **In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| X-Rays | You pay $60 copayment. | You pay $55 copayment. | **In-Network:** You pay $55 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| Therapeutic Radiology (such as radiation treatment for cancer) | You pay 20% coinsurance. | You pay 20% coinsurance. | **In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Hearing Services**<br>Diagnostic Hearing Exam | You pay $45 copayment. | You pay $30 copayment. | **In-Network:**<br>You pay $30 copayment.<br>**Out-of-Network:**<br>You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| Routine Hearing Exam<br>(One routine hearing exam each year.) | **In-Network:**<br>You pay $0 copayment.<br>**Out-of-Network:**<br>Not covered. | **In-Network:**<br>You pay $0 copayment.<br>**Out-of-Network:**<br>Not covered. | **In-Network:**<br>You pay $0 copayment.<br>**Out-of-Network:**<br>Not covered. | You must see a TruHearing provider. One routine hearing exam each year. |
| Hearing Aids | **In-Network (per aid):**<br>$499 copay for Advanced Aid.<br>$799 copay for Premium Aid.<br>$50 additional cost for optional hearing aid rechargeability.<br>**Out-of-Network:**<br>Not covered. | **In-Network (per aid):**<br>$499 copay for Advanced Aid.<br>$799 copay for Premium Aid.<br>$50 additional cost for optional hearing aid rechargeability.<br>**Out-of-Network:**<br>Not covered. | **In-Network (per aid):**<br>$499 copay for Advanced Aid.<br>$799 copay for Premium Aid.<br>$50 additional cost for optional hearing aid rechargeability.<br>**Out-of-Network:**<br>Not covered. | You are eligible for hearing aids from TruHearing providers only. Copayments not included in the Out-of-Pocket Maximum. |
| **Dental Services**<br>Medicare covered limited dental services. | You pay $45 copayment. | You pay $30 copayment. | **In-Network:**<br>You pay $30 copayment.<br>**Out-of-Network:**<br>You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | Does not include routine services in connection with care, replacement of teeth, treatment, filling, or removal. Medicare only covers limited dental procedures under specific conditions. For each service, we pay up to an annual allowance. |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Dental Services (continued)**<br>Preventive dental services<br>(Includes up to 2 cleaning(s), dental x-ray(s), and oral exam(s) per year.) | **In-Network:**<br>You pay $0 copayment per service. | **In-Network:**<br>You pay $0 copayment per service. | **In-Network:**<br>You pay $0 copayment per service. | For out-of-network services, your plan will pay 100% of the allowance or dentist's charges, whichever is less. You are responsible for balances up to the dentist's charge. |
| Annual Allowance | $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility). | $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility). | $1,000 per calendar year for in and out of network benefits (services above the limit are your responsibility). | You will be responsible for the additional cost if your provider does not participate in the network and charges more than the annual allowance.<br><br>Does not apply to preventive services. |
| Restorative (e.g., restorations)<br>Periodontics (e.g., scaling)<br>Oral Surgery (e.g., extractions)<br>Endodontics (e.g., root canal)<br>Prosthodontics (e.g., select crowns, dentures, and bridges)<br>Prosthetic Maintenance (e.g., denture or bridge repairs) | **In-Network:**<br>You pay $0 copayment per service.<br>**Out-of-Network:**<br>You pay $0 copayment per service. | **In-Network:**<br>You pay $0 copayment per service.<br>**Out-of-Network:**<br>You pay $0 copayment per service. | **In-Network:**<br>You pay $0 copayment per service.<br>**Out-of-Network:**<br>You pay $0 copayment per service. | See the Evidence of Coverage for more information.<br>Limited to specific dental codes<br>Exclusions apply, for example tooth implants are not covered. |

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| **Vision Services** Diagnostic/ Treatment Exam | **In-Network:** You pay $0 copayment. | **In-Network:** You pay $0 copayment. | You pay $0 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| Routine Eye Exam | **In-Network:** You pay $0 copayment. | **In-Network:** You pay $0 copayment. | **In-Network:** You pay $0 copayment. **Out-of-Network:** Not covered. | |
| Eyeglasses or Contacts after Cataract Surgery | You pay $45 copayment. | You pay $35 copayment. | **In-Network:** You pay $30 copayment. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| Routine Eyewear Allowance | $150 annual allowance | $150 annual allowance | $150 annual allowance | Allowance towards purchase of contact lenses and eyeglasses (frames and lenses). |
| **Mental Health Services** Inpatient Visit | You pay $374 copayment per day for days 1-5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. | You pay $315 copayment per day for days 1-5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. | **In-Network:** You pay $315 copayment per day for days 1-5. You pay $0 copayment for additional Medicare-covered days during your hospital admission. | Benefit applied per admission. Prior authorization is required. Covers up to 190 days lifetime for inpatient mental health care at a psychiatric hospital. The inpatient hospital care limit does |

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| **Mental Health Services (continued)**<br>Inpatient Visit<br><br>Individual and Group Outpatient Therapy Visit | You pay 20% coinsurance. | You pay 20% coinsurance. | **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year.<br><br>**In-Network:** You pay 20% coinsurance.<br>**Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. See the Evidence of Coverage for more information.<br><br>Prior Authorization may be required for some services. |
| **Skilled Nursing Facility** | You pay $0 copayment for days 1 through 20.<br><br>You pay a $218 copayment per day for days 21 through 100. | You pay $0 copayment for days 1 through 20.<br><br>You pay a $218 copayment per day for days 21 through 100. | **In-Network:** You pay $0 copayment for days 1 through 20.<br><br>You pay a $218 copayment per day for days 21 through 100.<br>**Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization is required. We cover up to 100 days in a Skilled Nursing Facility. |
| **Physical Therapy** | You pay $35 copayment. | You pay $35 copayment. | **In-Network:** You pay $30 copayment.<br>**Out-of-Network:** You pay 30% coinsurance. Will | Prior Authorization may be required. |

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| **Physical Therapy (continued)** | | | reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| **Ambulance** | You pay $300 copayment. | You pay $250 copayment. | You pay $275 copayment. | Prior Authorization may be required. |
| **Transportation** | Not Covered. | Not Covered. | Not Covered. | |
| **Medicare Part B Drugs**<br><br>**Part B Insulin used in a traditional insulin pump** | You pay 20% coinsurance.<br><br>You pay $35 copayment. | You pay 20% coinsurance.<br><br>You pay $35 copayment. | **In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance. Will reimburse max $1,500 for out-of-network (POS) services per calendar year.<br><br>**In-Network:** You pay $35 copayment. **Out-of-Network:** You pay $35 copayment. | Prior Authorization may be required. Part B drugs may be subject to step therapy requirements.<br><br>For Part B chemotherapy drugs, the baseline cost sharing is 20% with a 0-20% range for drugs impacted by the Inflation Rebate Program. Drugs and cost can change quarterly. |
| **Medicare Part D Prescription Drugs** | | | | |
| **Phase 1: Initial Coverage** | Cost-sharing may vary depending on the pharmacy you choose and what phase of the Part D benefit you are in. For more information, please call us or view the Evidence of Coverage. Insulin costs will be a copayment or coinsurance based on your plan benefit, the maximum fair price for a covered insulin or the negotiated price under your plan, whichever is less. The maximum insulin copayment is $35 for a one-month supply. Insulins are not subject to the deductible; costs will be the same through the deductible and initial coverage phases of your benefit. | | | |
| **Deductible** There is no medical deductible. | $615 per year for prescription drugs on Tiers 2, 3, 4 and 5. | $615 per year for prescription drugs on Tiers 2, 3, 4 and 5. | $300 per year for prescription drugs on Tiers 3, 4 and 5. | You must pay your Part D deductible before the plan will contribute to the |

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|---|---|---|---|---|
| **Deductible (continued)** | | | | costs of your prescriptions. |
| **Tier 1 Preferred Generic** | | | | |
| **Preferred Pharmacy 30-day supply** | Tier 1:<br>You pay $6<br>Insulin:<br>You pay lesser of $6 or 25% | Tier 1:<br>You pay $5<br>Insulin:<br>You pay lesser of $5 or 25% | Tier 1:<br>You pay $0<br>Insulin:<br>You pay lesser of $0 or 25% | |
| **Standard Pharmacy 30-day supply** | Tier 1:<br>You pay $11<br>Insulin:<br>You pay lesser of $11 or 25% | Tier 1:<br>You pay $10<br>Insulin:<br>You pay lesser of $10 or 25% | Tier 1:<br>You pay $5<br>Insulin:<br>You pay lesser of $5 or 25% | |
| **Preferred Pharmacy/Mail Order 90-day supply** | Tier 1:<br>You pay $18<br>Insulin:<br>You pay lesser of $18 or 25% | Tier 1:<br>You pay $15<br>Insulin:<br>You pay lesser of $15 or 25% | Tier 1:<br>You pay $0<br>Insulin:<br>You pay lesser of $0 or 25% | |
| **Standard Pharmacy 90-day supply** | Tier 1:<br>You pay $33<br>Insulin:<br>You pay lesser of $33 or 25% | Tier 1:<br>You pay $30<br>Insulin:<br>You pay lesser of $30 or 25% | Tier 1:<br>You pay $10<br>Insulin:<br>You pay lesser of $5 or 25% | |
| **Tier 2 Generic** After you pay your deductible | | | | |
| **Preferred Pharmacy 30-day supply** | Tier 2:<br>You pay $15<br>Insulin:<br>You pay lesser of $15 or 25% | Tier 2:<br>You pay $15<br>Insulin:<br>You pay lesser of $15 or 25% | Tier 2:<br>You pay $5<br>Insulin:<br>You pay lesser of $5 or 25% | |
| **Standard Pharmacy 30-day supply** | Tier 2:<br>You pay $20<br>Insulin:<br>You pay lesser of $20 or 25% | Tier 2:<br>You pay $20<br>Insulin:<br>You pay lesser of $20 or 25% | Tier 2:<br>You pay $10<br>Insulin:<br>You pay lesser of $10 or 25% | |
| **Preferred Pharmacy/Mail Order 90-day supply** | Tier 2:<br>You pay $45<br>Insulin:<br>You pay lesser of $45 or 25% | Tier 2:<br>You pay $45<br>Insulin:<br>You pay lesser of $45 or 25% | Tier 2:<br>You pay $10<br>Insulin:<br>You pay lesser of $10 or 25% | |
| **Standard Pharmacy 90-day supply** | Tier 2:<br>You pay $60<br>Insulin:<br>You pay lesser of $60 or 25% | Tier 2:<br>You pay $60<br>Insulin:<br>You pay lesser of $60 or 25% | Tier 2:<br>You pay $20<br>Insulin:<br>You pay lesser of $20 or 25% | |

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| **Tier 3 Preferred Brand** After you pay your deductible | | | | |
| **Preferred Pharmacy 30-day supply** | Tier 3:<br>You pay 20%<br>Insulin:<br>You pay lesser of $30 or 20% | Tier 3:<br>You pay 21%<br>Insulin:<br>You pay lesser of $30 or 21% | Tier 3:<br>You pay 20%<br>Insulin:<br>You pay lesser of $30 or 20% | |
| **Standard Pharmacy 30-day supply** | Tier 3:<br>You pay 25%<br>Insulin:<br>You pay lesser of $35 or 25% | Tier 3:<br>You pay 25%<br>Insulin:<br>You pay lesser of $35 or 25% | Tier 3:<br>You pay 20%<br>Insulin:<br>You pay lesser of $35 or 20% | |
| **Preferred Pharmacy/Mail Order 90-day supply** | Tier 3:<br>You pay 20%<br>Insulin:<br>You pay lesser of $90 or 20% | Tier 3:<br>You pay 21%<br>Insulin:<br>You pay lesser of $90 or 21% | Tier 3:<br>You pay 20%<br>Insulin:<br>You pay lesser of $60 or 20% | |
| **Standard Pharmacy 90-day supply** | Tier 3:<br>You pay 25%<br>Insulin:<br>You pay lesser of $105 or 25% | Tier 3:<br>You pay 25%<br>Insulin:<br>You pay lesser of $105 or 25% | Tier 3:<br>You pay 20%<br>Insulin:<br>You pay lesser of $70 or 20% | |
| **Tier 4 Non-Preferred Drug** After you pay your deductible | | | | |
| **Preferred Pharmacy 30-day supply** | Tier 4:<br>You pay 30%<br>Insulin:<br>You pay lesser of $30 or 25% | Tier 4:<br>You pay 25%<br>Insulin:<br>You pay lesser of $30 or 25% | Tier 4:<br>You pay 33%<br>Insulin:<br>You pay lesser of $30 or 25% | |
| **Standard Pharmacy 30-day supply** | Tier 4:<br>You pay 40%<br>Insulin:<br>You pay lesser of $35 or 25% | Tier 4:<br>You pay 40%<br>Insulin:<br>You pay lesser of $35 or 25% | Tier 4:<br>You pay 50%<br>Insulin:<br>You pay lesser of $35 or 25% | |
| **Preferred Pharmacy/Mail Order 90-day supply** | Tier 4:<br>You pay 30%<br>Insulin:<br>You pay lesser of $90 or 25% | Tier 4:<br>You pay 25%<br>Insulin:<br>You pay lesser of $90 or 25% | Tier 4:<br>You pay 33%<br>Insulin:<br>You pay lesser of $60 or 25% | |
| **Standard Pharmacy 90-day supply** | Tier 4:<br>You pay 40%<br>Insulin:<br>You pay lesser of $105 or 25% | Tier 4:<br>You pay 40%<br>Insulin:<br>You pay lesser of $105 or 25% | Tier 4:<br>You pay 50%<br>Insulin:<br>You pay lesser of $70 or 25% | |
| **Tier 5 Specialty** After you pay your deductible | | | | |

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| **Preferred Pharmacy 30-day supply** | Tier 5:<br>You pay 30%<br>Insulin:<br>You pay lesser of $30 or 25% | Tier 5:<br>You pay 25%<br>Insulin:<br>You pay lesser of $30 or 25% | Tier 5:<br>You pay 29%<br>Insulin:<br>You pay lesser of $30 or 25% | |
| **Standard Pharmacy 30-day supply** | Tier 5:<br>You pay 40%<br>Insulin:<br>You pay lesser of $35 or 25% | Tier 5:<br>You pay 40%<br>Insulin:<br>You pay lesser of $35 or 25% | Tier 5:<br>You pay 29%<br>Insulin:<br>You pay lesser of $35 or 25% | |
| **Preferred Pharmacy/Mail Order 90-day supply** | Tier 5:<br>You pay 30%<br>Insulin:<br>You pay lesser of $90 or 25% | Tier 5:<br>You pay 25%<br>Insulin:<br>You pay lesser of $90 or 25% | Tier 5:<br>You pay 29%<br>Insulin:<br>You pay lesser of $60 or 25% | |
| **Standard Pharmacy 90-day supply** | Tier 5:<br>You pay 40%<br>Insulin:<br>You pay lesser of $105 or 25% | Tier 5:<br>You pay 40%<br>Insulin:<br>You pay lesser of $105 or 25% | Tier 4:<br>You pay 29%<br>Insulin:<br>You pay lesser of $70 or 25% | |
| **Phase 2: Catastrophic Coverage** | In 2026, once you have paid **$2,100** (including your deductible, copayments, and coinsurances) you enter the catastrophic coverage stage. **You pay $0 for generics and brand drugs** and will remain in this stage for the rest of the calendar year. On January 1, 2027, you begin again in the deductible phase. | | | |
| **Additional Benefits** | | | | |
| **Over the counter (OTC) Items** | You have $30 every quarter to spend on plan-approved OTC items. | You have $30 every quarter to spend on plan-approved OTC items. | You have $30 every quarter to spend on plan-approved OTC items. | Non-prescription OTC health related items are covered. Visit **medicare.Univerahealthcare.com** for details. |
| **Acupuncture** | You pay 50% coinsurance. | You pay 50% coinsurance. | **In-Network:**<br>You pay 50% coinsurance<br>**Out-of-Network:**<br>Not covered | For up to 10 visits per calendar year or up to 20 visits per calendar year for chronic lower back pain. |
| **Meals** | Not Covered. | Not Covered. | Not Covered. | |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Rehabilitation Services**<br>Occupational Therapy Visit | You pay $35 copayment. | You pay $35 copayment. | **In-Network:** You pay $30 copayment.<br>**Out-of-Network:** You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization may be required. |
| Speech and Language Therapy Visit | You pay $35 copayment. | You pay $35 copayment. | **In-Network:** You pay $30 copayment.<br>**Out-of-Network:** You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year. | |
| Cardiac rehabilitation Services | You pay $0copayment. | You pay $0 copayment. | **In-Network:** You pay $0 copayment.<br>**Out-of-Network:** You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year | |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Foot Care (Podiatry Services)**<br>Diagnostic Exams and Treatment | You pay $45 copayment. | You pay $30 copayment. | **In-Network:**<br>You pay $30 copayment.<br><br>**Out-of-Network:**<br>You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year | |
| Routine Foot Care | You pay $45 copayment. | You pay $30 copayment. | **In-Network:**<br>You pay $30 copayment.<br><br>**Out-of-Network:**<br>You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year | Routine foot exams and treatment are covered if you have Diabetes-related nerve damage and/or meet certain conditions. |
| **Medical Equipment/ Supplies**<br>Durable Medical Equipment (e.g., Wheelchairs, Oxygen) | You pay 20% coinsurance. | You pay 20% coinsurance. | **In-Network:**<br>You pay 20% coinsurance.<br>**Out-of-Network:**<br>You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year | Prior Authorization is required for Durable Medical Equipment. |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Medical Equipment/ Supplies (continued)** Prosthetics (e.g., Braces, Artificial Limbs and related supplies) | You pay 20% coinsurance. | You pay 20% coinsurance. | **In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization is required for Prosthetics. |
| Diabetes monitoring supplies | You pay $5 copayment. | You pay $5 copayment. | **In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year. | Abbott Diabetes Care is the preferred supplier for Diabetic Monitoring supplies. Your provider must get an approval from the plan before we'll pay for supplies from a non- preferred manufacturer. See the Evidence of Coverage for more information. |
| Diabetes self-management training | You pay a $0 copayment. | You pay a $0 copayment. | **In-Network:** You pay $5 copayment. **Out-of-Network:** You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year. | |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Medical Equipment/ Supplies (continued)** Therapeutic shoes or inserts | 20% coinsurance. | 20% coinsurance. | **In-Network:** 20% coinsurance. **Out-of-Network:** You pay 30% coinsurance per visit. Plan will reimburse a max of $1,500 for out-of-network (POS) services per calendar year. | For people with Diabetes who have severe diabetic foot disease. |
| **Wellness Programs Fitness** Silver&Fit participating fitness centers<br><br>Silver&Fit Home Fitness Kits | You pay a $0 annual fee.<br><br>You pay a $0 annual fee. | You pay a $0 annual fee.<br><br>You pay a $0 annual fee. | You pay a $0 annual fee.<br><br>You pay a $0 annual fee. | Nonparticipating fitness centers are not covered.Please see your Evidence of Coverage for more details. |
| **Remote Access Technology** | Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 711). | Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 711). | Contact a nurse 24 hours a day, 7 days a week at 1-800-348-9786 (TTY 711). | Intended to educate, not replace the advice of a medical professional. |
| **Routine Annual Physical Exam** | You pay $0 copayment. | You pay $0 copayment. | **In-Network:** You pay $0 copayment. **Out-of-Network:** Not covered. | One annual routine physical exam each calendar year. |
| **Immunizations** | **In-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines.<br>You pay 20% coinsurance for all other Medicare-Part B covered immunizations. | **In-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines.<br>You pay 20% coinsurance for all other Medicare-Part B covered immunizations. | **In-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines.<br>You pay 20% coinsurance for all other Medicare-Part B covered immunizations. | Some vaccines are also covered under our Part D prescription drug benefit. |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Immunizations (continued)** | | | **Out-of-Network:** You pay $0 copay for flu, hepatitis B, COVID-19, and pneumococcal vaccines. For all other Medicare-Part B covered immunizations, you pay 30%. Plan will reimburse max $1,500 for out-of-network (POS) services per calendar year. | |
| **Telehealth**<br>Primary<br><br>Specialists<br><br>Behavioral Health visit<br><br>Preferred partners:<br>Provider visit<br><br>Behavioral Health visit<br><br>Out-of-Network | You pay $5 copayment.<br><br>You pay $45 copayment.<br><br>You pay 20% coinsurance.<br><br>You pay $5 copayment.<br><br>You pay $45 copayment.<br><br>Not covered | You pay $5 copayment.<br><br>You pay $30 copayment.<br><br>You pay 20% coinsurance.<br><br>You pay $5 copayment.<br><br>You pay $30 copayment.<br><br>Not covered | You pay $5 copayment.<br><br>You pay $30 copayment.<br><br>You pay 20% coinsurance.<br><br>You pay $5 copayment.<br><br>You pay $30 copayment.<br><br>Not covered | For non-emergency medical issues only. Contact a network doctor by phone or secure video using your computer or mobile device. Telehealth doctors can diagnose symptoms and prescribe medication. Services available 24 hour a day, 7 days a week. |
| **Chiropractic** | You pay $15 copayment. | You pay $15 copayment. | **In-Network:** You pay $15 copayment. **Out-of-Network:** You pay 30% per visit. Plan will reimburse max $1,500 for out-of-network (POS) services per calendar year. | We only cover manual manipulation of the spine to correct a subluxation (when 1 or more of the bones in your spine move out of position). |

| Premiums and Benefits | Univera SeniorChoice® Extra (HMO) | Univera SeniorChoice® Basic (HMO) | Univera SeniorChoice® Advanced (HMO-POS) | What You Should Know |
|---|---|---|---|---|
| **Home Health Care** | You pay $0 copayment. | You pay $0 copayment. | **In-Network:** You pay $0 copayment. **Out-of-Network:** You pay 30% per visit. Plan will reimburse max $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization is required. |
| **Outpatient Dialysis Services** | You pay 20% coinsurance. | You pay 20% coinsurance. | **In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 20% coinsurance. | |
| **Outpatient Substance Abuse Services** Individual and Group therapy visit | You pay 20% coinsurance. | You pay 20% coinsurance. | **In-Network:** You pay 20% coinsurance. **Out-of-Network:** You pay 30% per visit. Plan will reimburse max $1,500 for out-of-network (POS) services per calendar year. | Prior Authorization may be required for some services. |

**Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**

**English**: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-883-9577 (TTY: 1-800-662-1220) or speak to your provider.

**Spanish**: Si habla inglés, hay servicios gratuitos de asistencia lingüística disponibles. También se ofrecen de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-883-9577 (TTY: 1-800-662-1220) o hable con su proveedor.

**Chinese-Traditional:** 如果您說英文，我們可免費提供語言援助服務。此外，我們亦可免費提供適當的輔助工具及服務，以協助您取得無障礙格式的資訊。請致電 1-877-883-9577（TTY：1-800-662-1220），或洽詢您的醫療服務提供者。

**Russian:** Если вы говорите по-английски, вам доступны бесплатные услуги языковой поддержки. Кроме того, бесплатно предоставляются соответствующие вспомогательные услуги и сервисы для предоставления информации в доступных форматах. Позвоните по номеру 1-877-883-9577 (телетайп: 1-800-662-1220) или обратитесь к своему поставщику услуг.

**Haitian Creole:** Si w pale Anglè, gen sèvis asistans lengwistik ki disponib gratis pou ou. Gen aparèy ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòma ki aksesib ki disponib gratis tou. Rele nan 1-877-883-9577 (TTY: 1-800-662-1220) oswa pale ak pwofesyonèl swen sante w la.

**Korean:** 영어를 구사하는 경우 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 이용 가능합니다. 1-877-883-9577(TTY: 1-800-662-1220)로 전화하거나 서비스 제공업체에 문의하십시오.

**Italian:** Se parla inglese, potrà usufruire di servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente adeguati servizi sussidiari e di assistenza per fornire informazioni in formati accessibili. Chiamare il numero 1-877-883-9577 (TTY: 1-800-662-1220) o consultare il proprio fornitore.

**Yiddish:** אויב איר רעדט ענגליש, זענען פרייַ שפּראַך הילף סערוויסעס פאראנען פאר אייך. פאסיקע הילפסמיטלען און סערוויסעס צו צושטעלן אינפארמציע אין צוטריטלעכע פארמאַטן זענען אויך פאראנען פריי פון אפּצאל. איינרוף 1-877-883-9577 (TTY: 1-800-662-1220) אדער רעדט מיט אייער פראווייַדער.

**Bengali:** আপনি যদি ইংরেজি বলতে পারেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য রয়েছে। তথ্য সহজলভ্য বিন্যাসে প্রদানের জন্য উপযুক্ত সহায়ক সরঞ্জাম এবং পরিষেবা বিনামূল্যে পাওয়া যায়। 1-877-883-9577 (TTY: 1-800-662-1220) নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

**Polish:** Jeśli mówi Pan/Pani po angielsku, może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. W celu dostarczenia informacji w przystępnym formacie dostępne są również bezpłatne dodatkowe pomoce i usługi. Prosimy zadzwonić pod numer 1-877-883-9577 (TTY: 1-800-662-1220) lub porozmawiać ze swoim świadczeniodawcą.

**Arabic:** إن كنت تتحدث الإنجليزية، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر المساعدات والخدمات الإضافية الملائمة لتقديم المعلومات بصيغ يسهل الوصول إليها مجانًا. اتصل بهذا الرقم 1-877-883-9577 (رقم الهاتف النصي لضعاف السمع TTY: 1-800-662-1220) أو تحدث إلى مُقدم الرعاية الخاص بك.

**French:** Si vous parlez anglais, des services d'assistance linguistique vous sont proposés gratuitement. Des aides et des services auxiliaires adaptés pour vous fournir des informations dans des formats accessibles vous sont également proposés gratuitement. Appelez le 1-877-883-9577 (TTY : 1-800-662-1220) ou parlez-en à votre prestataire.

**Urdu:** اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت زبان میں معاونت کی خدمات دستیاب ہیں۔ معلومات کو قابل رسائی انداز میں فراہم کرنے کے لیے مناسب معاون آلات اور خدمات بھی مفت فراہم کی جاتی ہیں۔ 1-877-883-9577پر کال کریں (TTY: 1-800-662-1220) یا اپنے فراہم کنندہ سے بات کریں۔

**Tagalog:** Kung nagsasalita ka ng English, available para sa iyo ang mga libreng serbisyo ng tulong sa wika. Available din nang libre ang mga naaangkop na karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-883-9577 (TTY: 1-800-662-1220) o makipag-usap sa iyong provider.

**Greek:** Εάν μιλάτε Αγγλικά, είναι διαθέσιμες για εσάς δωρεάν υπηρεσίες γλωσσικής βοήθειας. Επίσης, διατίθενται χωρίς χρέωση κατάλληλα βοηθητικά μέσα και υπηρεσίες για την παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε στο 1-877-883-9577 (TTY: 1-800-662-1220) ή μιλήστε με τον πάροχό σας.

**Albanian:** Nëse flisni anglisht, ofrohen falas për ju shërbime të asistencës gjuhësore. Gjithashtu ofrohen falas mjete dhe shërbime ndihmëse të përshtatshme për të ofruar informacionin në formate të aksesueshme. Telefononi 1-877-883-9577 (TTY: 1-800-662-1220) ose flisni me ofruesin tuaj.

# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a representative at 1-800-659-1986.

## Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit medicare.univerahealthcare.com or call 1-800-659-1986 to view a copy of the EOC.

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit medicare.univerahealthcare.com or call 1-800-659-1986 to request a copy of the EOC.

- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

- ☐ Review the formulary to make sure your drugs are covered.

## Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.

- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory). Check the EOC for more information.

- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Univera Healthcare contracts with the Federal Government and is an HMO plan with a Medicare contract. Enrollment in Univera Healthcare depends on contract renewal.

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