

# 2027 Plan Guide

**University of Arkansas System**

UnitedHealthcare® Group Medicare Advantage (PPO)

**Group Number:** 13571

**Effective:** January 1, 2027 through December 31, 2027

United Healthcare®
Group Medicare Advantage

UofA
UNIVERSITY OF ARKANSAS SYSTEM

# With the UnitedHealthcare Group Medicare Advantage (PPO) plan, you get more

Your former employer or plan sponsor has selected UnitedHealthcare® to offer health care and prescription drug coverage to their Medicare-eligible retirees. With this plan, you'll enjoy an easier than ever Medicare experience. You've earned it.



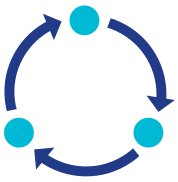
## Read through this Plan Guide to get to know your new plan

The guide includes:

- A description of the plan and how it works
- Information about benefits, programs and services, and how much they cost
- Information about covered drugs and how much they cost
- What you can expect after you're enrolled in the plan

Please keep this Plan Guide. It has information that will be helpful once you become a member.

Visit **retiree.uhc.com** to get plan information and more. Select the **Chat now** button to connect with one of our knowledgeable Customer Service Advocates. You can also use the Group Number on the front cover of this book to access plan materials online.



## How to enroll

**1** Find the Enrollment Request Form near the end of this guide
**2** Fill out the form completely — making sure to sign and date the form
**3** Return your completed form to the address or fax number on the form before your enrollment deadline



## Take control of your health

We can help you get access to the care you need when you need it. Let us help you find ways to save money on your health care so you can focus on what matters most to you.

# More ways to use your benefits

## Once you're a member, you'll receive your new UnitedHealthcare UCard® in the mail

Your UCard is your member ID — and much more. It makes it easier to access your benefits and programs, so you can take advantage of what your plan has to offer. Use your UCard when you:

**Check in at your provider or fill a prescription**

Your UCard has the plan information you and your providers need.

**Buy over-the-counter (OTC) products with your benefit card**

Use the credit loaded on your UCard as payment in-store or online.

**Go to the gym**

Show your UCard to access your free membership the first time you visit a network gym or fitness location.



# More than health insurance

With this UnitedHealthcare Group Medicare Advantage (PPO) plan you get medical and prescription drug coverage and so much more. More benefits. More savings. More experience. More choices. More convenience.

## Here's just some of what this plan offers

- **UnitedHealthcare UCard®,** your all-in-one member ID makes it easier to access your benefits and programs
- **Free extra support after a hospital or skilled nursing facility stay,** including home-delivered meals, transportation to medical appointments and the pharmacy, and non-medical personal care
- **Earn rewards** to spend on eligible items like gifts, clothing, groceries and more
- **Free delivery with Optum® Home Delivery Pharmacy** for prescriptions you take regularly*
- **Free standard gym membership** at participating locations
- **Free Optum® HouseCalls visit** from one of our licensed health care practitioners
- **$0 copay for a hearing exam** and $500 allowance to spend on a broad selection of hearing aids for both ears every 3 years
- **Virtual doctor and behavioral health visits** using your computer, tablet or smartphone – anytime, day or night
- **A large network of providers** through our Medicare National Network
- **Free diabetic supplies** like needles and test strips

**Review the Summary of Benefits in this guide for more details**

*Optum® Home Delivery Pharmacy and Optum Rx affiliates are not available in all areas.

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# More from your health plan

Your PPO plan is a Medicare Advantage plan, also known as Medicare Part C. This plan has all the benefits of Medicare Part A (hospital coverage) and Medicare Part B (doctor and outpatient care) plus extra programs that go beyond Original Medicare (Medicare Parts A and B).

## You'll enjoy:

- **You pay a standard copay or coinsurance, or $0 in some cases,** to see a provider in or out-of-network
- **Access to a large network** of doctors, hospitals, and pharmacies equipped with tools to support your health
- **Prescription drug coverage** — use network pharmacies for the lowest drug cost
- **Worldwide coverage** for emergencies and urgent care

## How the plan works:

- Select a primary care provider (PCP) to oversee and help manage your care. The plan doesn't require you to have a PCP, but using a PCP is very beneficial for your long-term health and well-being.
- Get care from providers in or out-of-network as long as they accept Medicare and the plan.
- You don't need a referral to see a specialist or other provider.
- This plan has separate maximum annual out-of-pocket amounts for medical and prescription drugs.
- Review your Summary of Benefits to see what's covered.

**Scan this code to view the Drug List**

# More ways to learn about your plan



It's important that you understand your plan and what benefits are covered. You can find the Drug List, Provider and Pharmacy directories and more at **retiree.uhc.com**.

**Review the online Drug List (Formulary) to see what prescription drugs are covered**
And what drug tier they are in. Generally, the lower the drug tier, the less you'll pay.

**Review the online Provider Directory to see if your providers are in the network**
It's okay if they're not. This plan allows you to see out-of-network providers at the same cost share as long as they accept Medicare and the plan.

**Review the online Pharmacy Directory to see what pharmacies are in our network**
If your pharmacy is not in the network, you will need to select a new network pharmacy to pay your plan's lowest cost for prescription drugs.

**Review the Summary of Benefits in this guide to see how much you'll pay for medical services and prescription drugs**
You can also review the Summary of Benefits online.

If you're not sure if you are enrolled in Medicare Part B, check with Social Security at ssa.gov/locator or call 1-800-772-1213, TTY 1-800-325-0778, 8 a.m.–7 p.m., Monday–Friday, or call your local office.

You may be disenrolled from this plan if you stop paying your Medicare Part B premium.

## You're eligible to enroll in this plan if you:

Are entitled to Medicare Part A and enrolled in Medicare Part B.

Continue to pay your Part B premium (unless it's paid for you).

**Remember:** If you drop or are disenrolled from your group-sponsored retiree coverage, you may not be able to re-enroll. Limitations and restrictions vary by former employer or plan sponsor.

# Summary of Benefits 2027

**UnitedHealthcare® Group Medicare Advantage (PPO)**

Group Name (Plan Sponsor): University of Arkansas System
Group Number: 13571
H2001-816-000

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

Download the **UnitedHealthcare app**

Visit **retiree.uhc.com**

Call toll-free **1-800-533-2743**, TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

UnitedHealthcare® Group Medicare Advantage

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# Summary of Benefits

## January 1, 2027 - December 31, 2027

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can call Customer Service if you want a copy of the EOC or need help. When you enroll in the plan, you will get more information on how to view your plan details online.

## UnitedHealthcare® Group Medicare Advantage (PPO)

| Medical premium, deductible and limits | |
|---|---|
| | **In-network and out-of-network** |
| **Monthly plan premium** | Contact your group plan benefit administrator to determine your actual premium amount, if applicable. |
| **Annual medical deductible** | Your plan has an annual combined in-network and out-of-network medical deductible of $500 each plan year. |
| **Maximum out-of-pocket amount** (does not include prescription drugs) | Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,000 for this plan year.<br><br>If you reach the limit on out-of-pocket costs, you keep getting covered for hospital and medical services and we will pay the full cost for the rest of the plan year. Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs. |

| Medical benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **Inpatient hospital care**[1] | | $450 copay per stay |
| | | Our plan covers an unlimited number of days for an inpatient hospital stay. |
| **Outpatient hospital**[1] Cost sharing for additional plan covered services will apply. | Ambulatory surgical center (ASC) | $200 copay |
| | Outpatient surgery | $200 copay |
| | Outpatient hospital services, including observation | $200 copay |

| Medical benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **Doctor visits** | Primary care provider (PCP) | $25 copay |
| | Virtual visit | $0 copay |
| | Specialist[1] | $40 copay |
| **Preventive services** | Routine physical | $0 copay; 1 per plan year* |
| | Medicare-covered | $0 copay |
| | • Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Annual wellness visit<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screening<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings and monitoring<br>• Diabetes – Self-Management training<br>• Dialysis training<br>• Glaucoma screening<br>• Hepatitis C screening<br>• HIV screening<br>• Kidney disease education<br>• Lung cancer with low dose computed tomography (LDCT) screening<br>• Medical nutrition therapy services<br>• Medicare Diabetes Prevention Program (MDPP)<br>• Obesity screenings and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screenings and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19<br>• "Welcome to Medicare" preventive visit (one-time)<br>Any additional preventive services approved by Medicare during the contract year will be covered.<br>This plan covers preventive care screenings and annual physical exams at 100%. | |
| **Emergency care** | | $65 copay (worldwide)<br>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the "Inpatient Hospital Care" section of this booklet for other costs. |
| **Urgently needed services** | | $50 copay (worldwide)<br>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the urgently needed services copay. See the "Inpatient Hospital Care" section of this booklet for other costs. |

| Medical benefits | | | |
|---|---|---|---|
| | | In-network and out-of-network | |
| **Diagnostic tests, lab and radiology services, and X-rays** | Diagnostic radiology services (e.g. MRI, CT scan)[1] | 20% coinsurance | |
| | Lab services[1] | $0 copay | |
| | Diagnostic tests and procedures[1] | 20% coinsurance | |
| | Therapeutic radiology[1] | 20% coinsurance | |
| | Outpatient X-rays[1] | $0 copay | |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues[1] | $40 copay | |
| | Routine hearing exam | $0 copay, 1 exam per plan year* | |
| | Hearing Aids | $0 copayment for prescription hearing aids, combined for both ears, unlimited devices, every 3 years, up to the $500 allowance amount. | 90% coinsurance for prescription hearing aids, combined for both ears, unlimited devices, every 3 years, up to the $500 allowance amount.* |
| **Vision services** | Exam to diagnose and treat diseases and conditions of the eye[1] | $40 copay | |
| | Eyewear after cataract surgery | $0 copay | |
| | Routine eye exam | $0 copay, 1 exam every 12 months* | |
| **Mental health** | Inpatient visit[1] | $250 copay per stay<br>Our plan covers an unlimited number of days for an inpatient hospital stay. | |
| | Outpatient group therapy visit[1] | $25 copay | |
| | Outpatient individual therapy visit[1] | $25 copay | |
| | Outpatient therapy or office visit with a psychiatrist[1] | $25 copay | |
| | Virtual behavioral visits | $25 copay | |

| Medical benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **Skilled nursing facility (SNF)**[1] | | $20 copay per day: days 1-28<br>$0 copay per day: days 29-100<br><br>Our plan covers up to 100 days in a SNF per benefit period. |
| **Outpatient Rehabilitation (physical, occupational, or speech/language therapy)**[1] | | 20% coinsurance |
| **Ambulance**[2] | | $100 copay |
|  **Routine Transportation**<br>One-way trips to and from medically related appointments and the pharmacy, up to 50 miles per trip. Restrictions apply. | | Not covered |
| **Medicare Part B Drugs**<br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | Chemotherapy drugs[1] | 20% coinsurance |
| | Other Part B drugs[1] | 20% coinsurance |

| Prescription drugs | | |
|---|---|---|
| **Deductible** | $300<br>You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage. | |
| **Initial coverage** | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,400, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage. | |
| **Tier drug coverage**<br>(After you pay your deductible, if applicable) | **Retail Cost-Sharing**<br>**30-day supply** | **Mail Order Cost-Sharing**<br>**90-day supply** |
| **Tier 1:**<br>Preferred Generic | $15 copay | $30 copay |
| **Tier 2:**<br>Preferred Brand ˜ | $45 copay | $90 copay |
| **Tier 3:**<br>Non-Preferred Drug ˜ | $80 copay | $160 copay |

| Prescription drugs | | |
|---|---|---|
| **Tier 4:** Specialty Tier ˜ | $80 copay | $160 copay |
| **Catastrophic coverage** | Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information. | |

˜ You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible. Most adult Part D vaccines are covered at no cost to you.

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor offers drug coverage in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D benefit and your additional drug coverage. For more information, see your Additional Drug Coverage list. You can also view the Certificate of Coverage at retiree.uhc.com or call Customer Service to have a hard copy sent to you.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.




## You may qualify for Extra Help from Medicare

Extra Help is a program for people with limited incomes who need help paying Part D premiums, deductibles and copays. There's no penalty for applying, and you can re-apply every year. To see if you qualify for Extra Help, call:

- The Social Security Administration at 1-800-772-1213, TTY 1-800-325-0778
- Your state Medicaid office



## The UnitedHealthcare Savings Promise

UnitedHealthcare is committed to keeping your prescription drug costs down. As a UnitedHealthcare member, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan copay, the pharmacy's retail price or our contracted price with the pharmacy.

| Additional benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **Acupuncture services** | Medicare-covered acupuncture (for chronic low back pain) | $20 copay |
| **Chiropractic services** | Medicare-covered chiropractic care | $20 copay |

| Additional benefits | | | |
|---|---|---|---|
| | | In-network and out-of-network | |
| | (manual manipulation of the spine to correct subluxation)[1] | | |
| **Diabetes management** | Diabetes monitoring supplies[1] | $0 copay<br>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.<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>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus. | |
| | Medicare covered Continuous Glucose Monitors (CGMs) and supplies[1] | $0 copay | |
| | Diabetes self-management training[1] | $0 copay | |
| | Therapeutic shoes or inserts[1] | 20% coinsurance | |
| **Durable medical equipment (DME) and related supplies** | Durable Medical Equipment (e.g., wheelchairs, oxygen)[1] | 20% coinsurance | |
| | Prosthetics (e.g., braces, artificial limbs)[1] | 20% coinsurance | |
| **Fitness Program**<br>SilverSneakers, a health and fitness Fitness program program designed for Medicare plan members. SilverSneakers® includes a standard monthly membership at participating fitness locations.<br>Call or go online to learn more and to get your SilverSneakers ID number. 1-888-338-1722, TTY 711 or SilverSneakers.com/StartHere. | | $0 copay | 90% coinsurance if you use an out-of-network fitness provider |
| **Foot care (podiatry services)** | Foot exams and treatment[1] | $40 copay | |

| Additional benefits | | | |
|---|---|---|---|
| | | In-network and out-of-network | |
| | Routine foot care | $40 copay, 6 visits per plan year* | |
| **Over-the-counter (OTC) credit**<br>$40 credit each quarter to buy covered OTC products from network retail locations or through the website. Credits expire the last day of each quarter. | | $0 copay | 90% coinsurance if you use an out-of-network store or provider. The credit applies to remaining balance, up to the quarterly limit. |
|  **UnitedHealthcare Healthy at Home**<br>Post-discharge program<br>Benefits are available for up to 30 days following each inpatient hospital and skilled nursing facility (SNF) stay:<br>• Meals: 28 home-delivered meals, referral required<br>• Transportation: 12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required<br>• In-home Care: 6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required<br>Call Customer Service for more information, to request a referral after each discharge and to use your benefits | | $0 copay | 90% coinsurance if you use an out-of-network provider |
|  **Home health care**[1] | | 20% coinsurance | |
| **Hospice** | | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan. | |
| **Opioid treatment program services**[1] | | $0 copay | |
| **Outpatient substance use disorder services** | Outpatient group therapy visit[1] | $25 copay | |
| | Outpatient individual therapy visit[1] | $25 copay | |

| Additional benefits | |
|---|---|
| | **In-network and out-of-network** |
| **Renal dialysis**[1] | 20% coinsurance |

[1]Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.

[2]Authorization is required for non-emergency Medicare-covered ambulance air transportation. Authorization is not required for non-emergency Medicare-covered ambulance ground transportation. Emergency ambulance (ground or air) does not require authorization.

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

## About this plan

UnitedHealthcare® Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed below, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all U.S. territories.

## About providers and network pharmacies

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies and other providers. You can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare program. 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 **retiree.uhc.com** 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

UnitedHealthcare® Group Medicare Advantage (PPO) 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 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 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. For more information, please call Customer Service at the number on your UnitedHealthcare UCard® or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su UCard® de UnitedHealthcare o en la portada de la guía de su plan.

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

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

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. There may be other pharmacies in our network. Optum Home Delivery Pharmacy and Optum Rx affiliates are not available in all areas.

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

You must continue to pay your Medicare Part B premium.

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.

Always talk with your doctor before starting an exercise program.

1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.

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# Additional Drug Coverage

Your plan provides prescription drug coverage beyond what is listed in the plan's Drug List (Formulary).

**Your plan includes extra coverage for drugs not included on your plan's Drug List.**

The cost of these drugs is based on the tier each drug is placed in. You can find tier descriptions and costs in the Summary of Benefits.

| Drug name | Drug tier | Coverage rules or limits on use |
|---|---|---|
| **Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions** | | |
| **Inflammation** | | |
| Salsalate | 1 | |
| **Urinary Tract Pain** | | |
| Phenazopyridine | 1 | |
| **Anorexiants - drugs to promote weight loss** | | |
| Phentermine | 1 | QL (maximum of 1 capsule/tablet per day) |
| **Anticoagulants - drugs to prevent clotting** | | |
| Heparin Lock Flush | 1 | |
| **Dermatological agents - drugs to treat skin conditions** | | |
| **Dry, Itchy Skin** | | |
| Sulfacetamide Sodium (Liquid Wash 10%) | 1 | |
| Sulfacetamide Sodium w/Sulfur (Cream 10-5%) | 1 | |
| **Itching Or Pain** | | |
| Pramoxine/Hydrocortisone (Cream 1-2.5%) | 1 | |
| **Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions** | | |
| **Hemorrhoids** | | |
| Hydrocortisone Acetate (Suppository 25 mg) | 1 | |
| Lidocaine/Hydrocortisone (Perianal Cream 3%-0.5%) | 1 | |
| **Irritable Bowel Or Ulcers** | | |
| Hyoscyamine Sulfate | 1 | |
| **Levbid** | 3 | |

**Bold type = Brand name drug** Plain type = Generic drug

| Drug name | Drug tier | Coverage rules or limits on use |
|---|---|---|
| **Genitourinary agents - drugs to treat bladder, genital and kidney conditions** | | |
| **Erectile Dysfunction** | | |
| Avanafil | 1 | QL (maximum of 6 tablets per month) |
| **Edex** | 3 | QL (maximum of 6 cartridges per month) |
| Sildenafil (25 mg, 50 mg, 100 mg) | 1 | QL (maximum of 6 tablets per month) |
| Tadalafil | 1 | QL (maximum of 6 tablets per month) |
| Vardenafil | 1 | QL (maximum of 6 tablets per month) |
| **Sexual Desire Disorder** | | |
| **Addyi** | 3 | QL (maximum of 1 tablet per day) |
| **Vyleesi** | 3 | QL (maximum of 8 injections per 30 days) |
| **Urinary Tract Infection** | | |
| **Uro-MP (118 mg)** | 3 | |
| **Urinary Tract Spasm And Pain** | | |
| Belladonna Alkaloids & Opium (Suppositories) | 1 | MME, 7D, DL |
| **Hormonal agents - hormone replacement/modifying drugs** | | |
| **Thyroid Supplement** | | |
| **Armour Thyroid** | 3 | |
| NP Thyroid | 1 | |
| **Nutritional supplements - drugs to treat vitamin and mineral deficiencies** | | |
| **Potassium Supplement** | | |
| **Effer-K (Effervescent Tab 25 mEq)** | 3 | |
| **K-Phos (Tab)** | 3 | |
| **Vitamins And Minerals** | | |
| Cyanocobalamin (Injection) (Vitamin B12) (1000 mcg) | 1 | |
| Folic Acid (1 mg) (Rx only) | 1 | |
| Folic Acid-Vitamin B6-Vitamin B12 (Tablet 2.5-25-1 mg) | 1 | |

**Bold type = Brand name drug** Plain type = Generic drug

| Drug name | Drug tier | Coverage rules or limits on use |
|---|---|---|
| Phytonadione (Tab) | 1 | |
| Reno (Cap) | 1 | |
| Vitamin D (50,000 unit) (Rx only) | 1 | |
| **Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions** | | |
| **Cough And Cold** | | |
| Benzonatate (100 mg, 200 mg) | 1 | |
| Brompheniramine/Pseudoephedrine/ Dextromethorphan (Syrup) | 1 | |
| Guaifenesin/Codeine (Syrup) | 1 | DL |
| Hydrocodone Polst/Chlorpheniramine (ER Susp) (generic for Tussionex) | 1 | DL |
| Hydrocodone/Homatropine | 1 | DL |
| Promethazine/Codeine (Syrup) | 1 | DL |
| Promethazine/Dextromethorphan (Syrup) | 1 | |

**Bold type = Brand name drug** Plain type = Generic drug

Payments for these bonus drugs don't count towards your Medicare Part D out-of-pocket maximum.

You cannot file a Medicare appeal or grievance for these drugs and Extra Help from Medicare does not apply to these drugs.

Drugs with coverage rules or limits are noted in the chart and described below.

**QL - Quantity limits**
The plan only covers a certain amount of this drug for one copay or over a certain number of days. These limits can help ensure safe and effective use of the drug.

**MME - Morphine Milligram Equivalent**
Additional quantity limits may apply to all opioid drugs used to treat pain. This additional limit is called a cumulative Morphine Milligram Equivalent (MME). It is designed to monitor safe dosing levels of opioids for people who may be taking more than one opioid drug for pain management. If your doctor or prescriber prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor or prescriber can ask the plan to cover the additional quantity.

**7D - 7-day limit**
An opioid drug used to treat pain may be limited to a 7-day supply if you don't have a recent history of using opioids. This limit helps minimize long-term opioid use. If you are new to the plan and have a recent history of using opioids, the pharmacy may override the limit when appropriate. Drugs with coverage rules or limits are noted in the chart and described below.

**DL - Dispensing limit**
Dispensing limits apply to this drug. This drug is limited to a one-month supply per prescription.

BDL: U

This information is not a complete description of benefits. Contact the plan for more information.
Limitations, copay, and restrictions may apply.
Benefits and/or copay/coinsurance may change each plan/benefit year.
The Drug List may change at any time. You will receive notice when necessary.
This information is available for free in other languages. Please call our Customer Service number on the cover.

# Here's what you can expect next

Once you're a member, the UnitedHealthcare Customer Service team and your online account can help you access the care you need, when and how you need it. And your UnitedHealthcare UCard® makes it easier than ever to unlock more from your plan.



**You are here**
UnitedHealthcare will process your enrollment

Create your account to review your plan online

Receive your UCard in the mail

Coverage begins! Start using your plan

## Manage your plan online

If you haven't already, use your Medicare number or member ID number and email address to create an account at **retiree.uhc.com**. Online you can:

- Look up your latest claim information and complete your health assessment
- Find network providers, pharmacies, your Drug List and other plan information
- Learn more about health and wellness topics
- Sign up to get plan information and your Explanation of Benefits online
- Review UCard balances

## Once your coverage begins

- Schedule your annual wellness visit
- Schedule your yearly in-home Optum® HouseCalls visit to help support your health. Visit **optum.com/healthvisitUHC** to learn more
- Get your medications with free delivery through Optum® Home Delivery Pharmacy*

## Benefits and costs may change at the end of your plan year

Before your plan year ends, we'll send you an Annual Notice of Changes that explains what's changing for next year.

### Thank you for trusting UnitedHealthcare with your health care coverage

If you have any questions, please call the toll-free number on the back of this Plan Guide. This number will also be on your UCard when you get it.

**Scan this code to access the member site**

*Optum® Home Delivery Pharmacy and Optum Rx affiliates are not available in all areas.

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# Statements of understanding

**By enrolling in this plan, I agree to the following:**

- **This is a Medicare Advantage Plan contracted with the federal government. This is not a Medicare Supplement Plan.**
  I need to keep my Medicare Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party. To be eligible for this plan, I must live in the plan's service area and be a United States citizen or be lawfully present in the U.S.
- **The service area includes the 50 United States, the District of Columbia and all U.S. territories.**
  I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under this plan, when I am outside of the U.S. I am covered for emergency or urgently needed care.
- **I can only have one Medicare Advantage or Prescription Drug Plan at a time.**
  - Enrolling in this plan will automatically disenroll me from any other Medicare health plan.
  - If I enroll in a different Medicare Advantage Plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
  - If I disenroll from this plan, I will be automatically transferred to Original Medicare.
  - Enrollment in this plan is for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.
- **My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.**
  Medicare may also release my information for research and other purposes that follow all applicable federal statutes and regulations.
- **For members of the Group Medicare Advantage Plan.**
  I understand that when my coverage begins, I must get all of my medical and prescription drug benefits from the plan. Benefits and services provided by the plan and contained in the Evidence of Coverage (EOC) document will be covered. Neither Medicare nor the plan will pay for benefits or services that are not covered.

United Healthcare®
Group Medicare Advantage

# 2027 Enrollment Request Form

## 1. Plan information

Plan sponsor

University of Arkansas System

| Group number | GPS employer ID |
|---|---|
| 13571 | 24464 |
| GPS branch number | GPS Bill Group (as applicable) |
| 002 | |

**Effective date requested:** (i.e., your proposed effective date, or on what day your coverage should begin)

Plan sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form.

**To enroll in the UnitedHealthcare® Group Medicare Advantage (PPO) plan, please provide the following:**

## 2. Information about you (Please type or print in black or blue ink)

| Last name | First name | Middle initial |
|---|---|---|
| | | |
| Birth date | Sex: ☐ Male ☐ Female | |

| Home phone number | Mobile phone number | Medicare number |
|---|---|---|
| (  )  – | (  )  – | |

Stay on top of your plan and health with timely, helpful texts and calls. You can change your preferences at any time.

Check here to consent to receive texts from UnitedHealthcare at the mobile phone number you provided about:

☐ Important benefit information to help you manage your plan

☐ Reminders about preventive care or health screenings

You also agree to the texting terms and conditions at **uhc.com/txt-tcs**. Message frequency varies. Message and data rates may apply. Text STOP to opt out of a texting program.

☐ Check here to consent to receive calls from UnitedHealthcare and its affiliates at the phone number(s) you provided. This includes calls made using an autodialer or an artificial prerecorded voice.

Permanent residence street address **(Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address)**

| City | County | State | ZIP code |
|---|---|---|---|
| | | | |

Last name First name Medicare number

Mailing address **(only if it's different from above. You can give a P.O. Box)**

| City | State | ZIP code |
|---|---|---|
| | | |

Email address

You will receive some plan information, such as your Explanation of Benefits and Annual Notice of Changes, electronically (quicker than mail). We'll email you when new documents are ready to review online.

☐ Check here if you prefer to receive paper copies by mail. You can change your delivery preference at any time.

Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

**Will you have other prescription drug coverage in addition to our plan?** ☐ Yes ☐ No

If **"yes"**, what is it?

Name of other insurance

| Member number | Group number |
|---|---|
| | |
| Rx Bin | Rx PCN (optional) |
| | |

**Your answers to the following questions will not keep you from being enrolled in this plan:**

## 3. A few questions to help us manage your plan

**1. Which language or accessible format do you prefer for future plan information?**

☐ English ☐ Spanish

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

If you don't see the language or format you want, please call us toll-free at **1-800-533-2743**, (TTY **711)** during 8 a.m.-8 p.m. local time, Monday-Friday

**If no selection is made, you will receive plan information in English.**

**2. Do you or your spouse work?** ☐ Yes ☐ No

Last name First name Medicare number

**3. Do you have any health insurance other than Medicare, such as private insurance, Worker's Compensation, VA benefits or other employer coverage?** ☐ Yes ☐ No

If **"yes"**, please provide the following:

Name of the other health insurance

Member number for other health insurance

Payer ID for other health insurance

Do you give us permission to request and share your health information with the other health insurance company you listed above? ☐ Yes ☐ No

If **"yes"**, we'll request your records and share them with your other plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

**4. Do you give us permission to request your health information from your previous health insurance company?** ☐ Yes ☐ No

If **"yes"**, we'll request your records from your previous plan to keep your medical records complete and help support your care. You can opt out at any time on your member site or by calling Customer Service.

If **"yes"**, please complete the following:

| Name of previous health insurance company | Member number for previous health insurance company |
|---|---|

Payer ID for previous health insurance company

**5. Please give us the name of your primary care provider (PCP), clinic or health center.**

Provider or PCP full name

| Provider/PCP number | (Please enter the number exactly as it appears on the website or in the Provider Directory. It will be 10 to 12 digits. Don't include dashes.) |
|---|---|

Are you now seeing or have you recently seen this provider? ☐ Yes ☐ No

**6. Do you give us permission to share your health information with your network providers?** ☐ Yes ☐ No

If **"yes"**, we'll share your health information with your network providers so they can work together on your care. If **"no"**, your provider may still access some information as allowed by law to make sure you get the right care. You can change your preference at any time on your member site or by calling Customer Service. If you don't make a selection now, we'll automatically share your information with your network providers.

Last name First name Medicare number

**7. Do you live in a nursing home, long-term care facility, or senior community?** ☐ Yes ☐ No

If **"yes"**, please give us information on the nursing home, long-term care facility, or senior community:

Name

Address

| City | State | ZIP code |
|---|---|---|
| | | |

Date you moved there

## 4. ATTENTION – please sign and date

I understand that my signature on this enrollment request form means that I have read and understood the contents of this enrollment request form, including the Statements of Understanding, and that the information provided by me is accurate and complete. If my plan includes outpatient prescription drug benefits, I understand that my signature on this enrollment request form means that I will be automatically enrolled in my plan's outpatient prescription drug benefits which includes Part D and supplemental prescription drug coverage. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

**This enrollment request form must be signed, dated and received prior to your desired effective date. Upon receipt, the plan will process the form according to Medicare guidelines.**

**Signature of applicant/member/authorized representative** **Today's date**

## 5. Authorized representative information

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and I have received my UnitedHealthcare member ID card, I can call customer service at the number on my UnitedHealthcare member ID card to update my authorization information on file.

**Signature** **Today's date**

## 6. For Individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Last name First name Medicare number

**Signature** (of individual who assisted in completing this form) **Today's date**

| ☐ Plan representative, check here if you signed above and assisted in completing this form. | Relationship to applicant |
|---|---|
| Name | Phone number |

Address

**Sales representative/broker, please provide your signature and complete the information below:**

**Licensed sales representative/broker signature** **Today's date**

Licensed sales representative/broker name (please print)

| Agent/broker number | Referring broker number |
|---|---|

## 7. For office use only

Agent name

| Agent number | | NIPR number |
|---|---|---|
| Effective date | Group number | PBP number |

☐ SEP ☐ Employer Group SEP ☐ ICEP/IEP ☐ AEP (type) _____

**Please send this completed form to:**

United Healthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770

Fax: 888-950-1170
Fax the front and back of each page

## Notice of availability of language assistance services and alternate formats

**ATTENTION:** Free language assistance services and free communications in other formats, such as large print, are available to you. Call the toll-free number on your member identification card.

**ማሳሰቢያ፦ አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ እገዛ አገልግሎቶች እና ነፃ ተግባቦቶች እንደ ትልቅ እትም ባሉ ሌሎች ቅርፀቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያ ካርድዎ ላይ ያለውን ነፃ የስልክ ቁጥር ይደውሉ።

**ملاحظة:** إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل بالرقم المجاني المدون على بطاقة تعريف العضو خاصتك.

**দেখুন:** আপনি যদি **বাংলায় (Bengali)** কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা এবং বড় মুদ্রণের মতো অন্যান্য ফরম্যাটে যোগাযোগগুলি আপনার জন্য বিনামূল্যে উপলব্ধ। আপনার সদস্যের পরিচয়পত্রের কার্ডের টোল-ফ্রি নম্বরে কল করুন

**請注意**：如果您說**中文 (Chinese)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

**توجه:** اگر به زبان **فارسی (Farsi)** صحبت میکنید خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب های دیگر مانند چاپ بزرگ در دسترس شما هستند با شماره رایگان مندرج روی کارت شناسایی عضویت تان تماس بگیرید.

**ATTENTION** : Si vous parlez **français (French)**, des services d’assistance linguistique et des communications dans d’autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

**ATANSYON**: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

**ATENSION**: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

**注意事項：日本語 (Japanese)** を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

**알림 사항**: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

**UWAGA**: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

**ATENÇÃO**: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

**ВНИМАНИЕ**! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

**ATENCIÓN**: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro.

**PAUNAWA:** Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

**LƯU Ý**: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

**אויפמערק**: אויב איר רעדט **אידיש (Yiddish)**, קענט איר באקומען אומזיסטע שפראך הילף סערוויסעס און אומזיסטע קאמיוניקאציע אויף אנדערע פארמאטן, אזוי ווי גרויסע אותיות. רופט דעם אומזיסטן נומער אויף אייער מעמבער אידענטיפיקאציע קארטל.

# Notes & doodles

# Notes & doodles

# Notes & doodles

United Healthcare®
Group Medicare Advantage

UofA
UNIVERSITY OF ARKANSAS SYSTEM

With exclusive benefits for retirees like you, get more of what matters for your health with a Group Medicare Advantage plan from UnitedHealthcare.

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and select the **Chat now** button

Call toll-free **1-800-533-2743,** TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

**Scan this code to download the UnitedHealthcare app**

Important Plan Information
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