# 2027 Plan Guide

**APWU Health Plan**

UnitedHealthcare® Group Medicare Advantage (PPO)

**Group Number:** 13468

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

United Healthcare
Group Medicare Advantage

APWU HEALTH PLAN

# Enhance your coverage with the APWU Health Plan Medicare Advantage Plan

The APWU Health Plan offers a Medicare Advantage plan as an enhanced level of benefits for all Medicare-eligible federal retirees. If you choose to enroll in the Medicare Advantage plan for APWU Health Plan retirees, you will remain an APWU Health Plan member in the FEHB program.

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

It includes:

- A description of the plan and how it works
- Information about benefits, programs and services
- 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. You can also get plan information at retiree.uhc.com/APWUHP.

## How to enroll

If you are already enrolled in the APWU Health Plan High Option, you can call UnitedHealthcare at any time throughout the year to elect the UnitedHealthcare® Medicare Advantage (PPO) plan for APWU Health Plan.

If you are not yet a member of the APWU Health Plan High Option, you'll need to enroll during Open Season with the Office of Personnel Management (OPM). Once your enrollment into the High Option has been processed by OPM, you can call UnitedHealthcare to elect the UnitedHealthcare® Medicare Advantage (PPO) plan for APWU Health Plan.

## Here's just some of what the plan includes

- Monthly $100 Medicare Part B premium reduction
- National network
- No referrals required
- Dental coverage
- Vision coverage
- And much more!

# Compare plans

Review this side by side plan comparison to help you determine if the Medicare Advantage plan will meet your needs.

| Medical benefits | APWU Health Plan High Option with Medicare Parts A and B | APWU Health Plan Medicare Advantage Plan |
|---|---|---|
| **Annual medical deductible** | $0 | $0 |
| **Annual medical out-of-pocket maximum[1]** | $6,500/$13,000 | $0 |
| **Preventive services** | $0 | $0 |
| **Physician office visits (primary, specialist and virtual)** | $0 | $0 |
| **Hospital visits (inpatient and outpatient)** | $0 | $0 |
| **Emergency room or urgent care** | $0 | $0 |
| **Ambulance services** | $0 | $0 |
| **Acupuncture** | $25/26 visits | $0/unlimited visits |
| **Chiropractic care** | $25/24 visits | $0/unlimited visits |
| **Physical, speech and occupational therapy** | $0/60 visits per year combined | $0/unlimited visits |
| **Durable medical equipment** | $0 | $0 |
| **Diabetic supplies** | $0 | $0 |
| **Routine podiatry** | Not covered | $0/6 visits per year |
| **Hearing aid allowance every 3 years (combined for both ears)[2]** | $0 — up to $1,500 allowance | $0 — up to $1,500 allowance |

| Pharmacy benefits | APWU Health Plan High Option with Medicare Parts A and B | APWU Health Plan Medicare Advantage Plan |
|---|---|---|
| **Retail pharmacy** | | |
| **Tier 1:** Generic | $10 | $10 |
| **Tier 2:** Preferred brand | 25% up to max of $200 | $30 |
| **Tier 3:** Non-preferred brand | 25% up to max of $300 | $45 |
| **Tier 4:** Specialty tier | 25% up to max of $300 | $60 |
| **Mail order pharmacy** | | |
| **Tier 1:** Generic | $20 | $20 |
| **Tier 2:** Preferred brand | 25% up to max of $300 | $60 |
| **Tier 3:** Non-preferred brand | 25% up to max of $500 | $90 |
| **Tier 4:** Specialty tier | 25% up to max of $150 | $120 |

These pharmacy benefits are based on the APWU Health Plan High Option Part D prescription drug plan.

## More benefits. No additional premium.

Enjoy these extras at no additional premium to your High Option plan.

**$100**

**Monthly Part B premium reduction**

**Vision eyewear allowance**

**Free gym membership**

**Dental coverage**

**$60**

**Quarterly credit for over-the-counter items**

**Home delivered meals**

## Important information

**Enrollment information:**
If you elect to enroll in the Medicare Advantage plan it will take over as the primary and only payer so you will not need to coordinate benefits, however, you must remain enrolled in the APWU Health Plan High Option if you elect the Medicare Advantage plan. Do not suspend or cancel your coverage with OPM or you will also be terminated from the Medicare Advantage plan.

**Disenrollment Information**
Enrollment is voluntary and retirees may opt in or out of the Medicare Advantage enhanced benefits at any time throughout the year. If you elect to disenroll from the Medicare Advantage plan you will be moved back to Original Medicare primary with the High Option medical benefits secondary, and then auto-enrolled into the Optum Rx Part D Prescription Drug plan effective the first of the following month.

**Medicare Part B enrollment**
If you are a federal retiree, you are not required to take Medicare Part B to continue retiree coverage in the FEHB program, however, there are some advantages to having it. Having Medicare Part B makes you eligible for the Medicare Advantage plan for APWU Health Plan. You must continue to pay your Medicare Part B premiums if you elect to enroll in the Medicare Advantage plan.

**Medicare Part B Late Enrollment Penalty (LEP)**
If you didn't get Medicare Part B when you were first eligible, your monthly premium may go up. In most cases, you'll have to pay this penalty each time you pay your premiums, for as long as you have Medicare Part B. You must continue paying your Medicare Part B premium to be eligible for coverage under this APWU Health Plan-sponsored Medicare Advantage plan. If you stop paying your Medicare Part B premium, you may be disenrolled from this plan.

**Medicare Part D (LEP)**
Once you become a UnitedHealthcare® Medicare Advantage (PPO) plan for APWU Health Plan member, you may receive a letter to confirm you have had continuous prescription drug coverage. If you had coverage through the APWU High Option Plan or another FEHB or PSHB plan since you became Medicare eligible, you had what is known as "creditable coverage" and a penalty will not apply. You simply need to respond to the letter as quickly as possible to avoid an unnecessary penalty.

**Income-Related Monthly Adjustment Amount (IRMAA)**
IRMAA is an amount Social Security determines you may need to pay in addition to your monthly Part B and D premium if your modified adjusted gross income on your IRS tax return from 2 years ago is above a certain limit. The UnitedHealthcare® Medicare Advantage (PPO) plan for APWU Health Plan's included prescription drug coverage is considered a Part D plan therefore if you currently have a Part B IRMAA then you may incur a Part D IRMAA when enrolling in this plan.

**Copay cards**
In most cases, coupons and prescription drug copay cards can't be used with a Part D plan. Copay cards include disclaimer language that state that they can't be used with federal health care programs. Part D prescription drug plans are a federal program.

Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply. Call your plan or review your Evidence of Coverage (EOC) for more information.

[1]Out-of-pocket maximum excludes premiums, prescription drug costs, and non-Medicare covered benefits.

[2]Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider. This information is not a complete description of benefits. Contact the plan for more information.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract, and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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# 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.

**Go to the gym**

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

**Spend your earned rewards**

Buy eligible items in-store at thousands of retailers nationwide.

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# Summary of Benefits 2027

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

Group Name (Plan Sponsor): APWU Health Plan
Group Number: 13468
H2001-857-000

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/APWUHP**

Call toll-free **1-855-383-8793**, TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

United Healthcare
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 see it online at **retiree.uhc.com/APWUHP** or you can call Customer Service for 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)

| Deductible and limits | |
|---|---|
| | **In-network and out-of-network** |
| **Part B premium reduction** | $100 monthly, per enrolled individual |
| **Maximum out-of-pocket amount** (does not include prescription drugs) | $0 for Medicare-covered services from any provider<br><br>Please note that you will still need to pay your cost-sharing for your Part D prescription drugs.<br>In addition, amounts you pay for some network and out-of-network services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. |

| Medical benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **Inpatient hospital care**[1] | | $0 copay per stay<br><br>Our plan covers an unlimited number of days for an inpatient hospital stay. |
| **Outpatient hospital**[1] | Ambulatory surgical center (ASC) | $0 copay |
| | Outpatient surgery | $0 copay |
| | Outpatient hospital services, including observation | $0 copay |
| **Doctor visits** | Primary care provider (PCP) | $0 copay |
| | Virtual visit | $0 copay |
| | Specialist[1] | $0 copay |

| Medical benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **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 | • 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) |
| | 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** | | $0 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** | | $0 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] | $0 copay | |
| | Lab services[1] | $0 copay | |
| | Diagnostic tests and procedures[1] | $0 copay | |
| | Therapeutic radiology[1] | $0 copay | |
| | Outpatient X-rays[1] | $0 copay | |
| **Hearing services** | Exam to diagnose and treat hearing and balance issues[1] | $0 copay | |
| | Routine hearing exam | $0 copay, 1 exam per plan year* | |
| | Hearing Aids | $0 copay for prescription hearing aids, combined for both ears, unlimited devices, every 3 years, up to the $1,500 allowance amount. | 90% coinsurance for prescription hearing aids, combined for both ears, unlimited devices, every 3 years, up to the $1,500 allowance amount.* |
| **Routine dental services** See Evidence of Coverage for more details. | Oral exams | $0 copay, 2 procedures per plan year. | |
| | Routine cleaning | $0 copay, 2 procedures per plan year. | |
| | Dental bitewing X-rays | $0 copay, 1 procedure per plan year. | |
| | Minor services (Includes fillings and nitrous oxide) | 20% coinsurance | |
| | Major Services (Includes Crowns, Root Canals, and other restorative services) | 50% coinsurance | |
| | Benefit limit | $50 yearly deductible<br>$1,000 combined in and out-of-network plan year maximum. Preventive and diagnostic procedures do not count toward this maximum.<br>If you receive services from an out-of-network dentist, the plan pays according to a maximum allowable fee schedule.<br>You pay all fees in excess of this amount. | |

| Medical benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **Vision services** | Exam to diagnose and treat diseases and conditions of the eye[1] | $0 copay |
| | Eyewear after cataract surgery | $0 copay |
| | Routine eye exam | $0 copay, 1 exam every 12 months* |
| | Routine eyewear | Plan pays up to $130 for eyeglasses, or up to $175 for contact lenses instead of eyeglasses, every 24 months.* |
| **Mental health** | Inpatient visit[1] | $0 copay per stay<br>Our plan covers an unlimited number of days for an inpatient hospital stay. |
| | Outpatient group therapy visit[1] | $0 copay |
| | Outpatient individual therapy visit[1] | $0 copay |
| | Outpatient therapy or office visit with a psychiatrist[1] | $0 copay |
| | Virtual behavioral visits | $0 copay |
| **Skilled nursing facility (SNF)[1]** | | $0 copay per day: days 1-20<br>$0 copay per day: days 21-100<br>Our plan covers up to 100 days in a SNF per benefit period. |
| **Outpatient Rehabilitation (physical, occupational, or speech/language therapy)[1]** | | $0 copay |
| **Ambulance[2]** | | $0 copay |
| **Ambulance, No Transport (Non-Medicare-Covered)** | | $0 copay |
| **Medicare Part B Drugs**<br>Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details. | Chemotherapy drugs[1] | $0 copay |
| | Other Part B drugs[1] | $0 copay |

| Prescription drugs | | |
|---|---|---|
| **Deductible** | The plan does not have a prescription drug deductible. Your coverage starts in 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 you move to the Catastrophic Coverage stage. | |
| **Tier drug coverage** (After you pay your deductible, if applicable) | **Retail Cost-Sharing** | **Mail Order Cost-Sharing** |
| | **30-day supply** | **90-day supply** |
| **Tier 1:** Preferred Generic | $10 copay | $20 copay |
| **Tier 2:** Preferred Brand ˜ | $30 copay | $60 copay |
| **Tier 3:** Non-Preferred Drug ˜ | $45 copay | $90 copay |
| **Tier 4:** Specialty Tier ˜ | $60 copay | $120 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. | |

˜ You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan. 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.

APWU Health Plan 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/APWUHP** 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

| Additional plan benefits | | |
|---|---|---|
| | | **In-network and out-of-network** |
| **Acupuncture services** | Medicare-covered acupuncture (for chronic low back pain) | $0 copay |
| | Routine acupuncture services | $0 copay for each visit per plan year* |
| **Chiropractic services** | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[1] | $0 copay |
| | Routine chiropractic services | $0 copay, for each visit per plan year* |
| **Diabetes manage-ment** | 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] | $0 copay |
| **Durable medical equipment (DME) and related supplies** | Durable Medical Equipment (e.g., wheelchairs, oxygen)[1] | $0 copay |
| | Prosthetics (e.g., braces, artificial limbs)[1] | $0 copay |

| Additional plan benefits | | | |
|---|---|---|---|
| | | **In-network and out-of-network** | |
| | **Fitness Program**<br>Renew Active, a health and fitness program designed for Medicare plan members. Renew Active includes a standard monthly membership at participating fitness locations. Sign in to your member site, look for My Coverage and select Access gym code or call the number on your UnitedHealthcare member ID card to obtain your code. | $0 copay | 90% coinsurance if you use an out-of-network fitness provider |
| **Foot care (podiatry services)** | Foot exams and treatment[1] | $0 copay | |
| | Routine foot care | $0 copay, 6 visits per plan year* | |
| | **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 |
| **UnitedHealthcare Healthy at Home Premium** | | $0 copay for the following benefits:<br>28 home-delivered meals<br>24 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip<br>8 hours of non-medical personal care services like companionship, meal prep, medication reminders, and | |

| Additional plan benefits | | | |
|---|---|---|---|
| | | In-network and out-of-network | |
| | | more with a professional caregiver<br>Call Customer Service for more information and to use your benefits. | |
| **Home health care**[1] | | $0 copay | |
| **Hospice** | | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan. | |
| **Opioid treatment program services**[1] | | $0 copay | |
| **Outpatient substance abuse disorder services** | Outpatient group therapy visit[1] | $0 copay | |
| | Outpatient individual therapy visit[1] | $0 copay | |
| **Over-the-counter (OTC) credit**<br>$60 credit each quarter to buy covered OTC products from network retail locations. Credits expire the last day of each quarter. | | $0 copay | 90% coinsurance if you use an out-of-network retail store. The credit applies to remaining balance, up to the quarterly limit. |
| **Renal dialysis**[1] | | $0 copay | |
| **Medical nutrition therapy (non-Medicare-covered)** | | $0 copay for each visit* | |

[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/APWUHP** 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.

The Renew Active® Program and its gym network varies by plan/area and may not be available on all plans. Participation in the Renew Active program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership at participating locations and other offerings. The participating locations and offerings may change at any time. Fitness membership equipment, classes and activities may vary by location. Certain classes are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

Participation in the fitness program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. The fitness program includes standard fitness membership and other offerings. Fitness membership equipment, classes, activities and events may vary by location. Certain services, discounts, classes, activities, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. Gym network may vary in local market and plan.

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# Additional Drug Coverage

APWU Health Plan provides prescription drug coverage beyond what is listed in the plan's Drug List (Formulary). There are different types of extra covered drugs. We've listed them below.

**You pay $0 for the drugs in the chart below.**

| **Allergic Reaction** |
|---|
| Epinephrine (Injection) |
| **Asthma** |
| Albuterol (HFA Inhaler) |
| Albuterol (Nebulized Solution) |
| **Birth Control** |
| (All oral contraceptives) (generic only) |
| Annovera (vaginal ring) |
| Kyleena (intrauterine device) |
| Liletta (intrauterine device) |
| Medroxyprogesterone (150mg/mL injection) |
| Mirena (intrauterine device) |
| Nexplanon (contraceptive implant) |
| EluRyng (vaginal ring) |
| Haloette (vaginal ring) |
| Skyla (intrauterine device) |
| Xulane (patch) |
| Zafemy (patch) |
| **Bowel Prep Products** |
| GaviLyte-C |
| GaviLyte-G |
| GaviLyte-N |
| PEG-3350/Electrolytes |
| PEG-3350/NaCl/Na Bicarbonate/KCl |
| **Breast Cancer Preventive Medications** |
| Anastrozole (1mg Tablet) |
| Exemestane (25mg Tablet) |
| Raloxifene (60mg Tablet) |
| Tamoxifen (10mg & 20mg Tablet) |
| **Breast Cancer Treatment** |
| Letrozole (2.5mg Tablet) |
| **Hypoglycemia (low blood sugar)** |
| Baqsimi |
| Glucagon |
| Zegalogue |
| **Insulin** |
| Humalog |
| Humulin |
| Lantus |
| Lyumjev |
| Toujeo |
| **Opioid Overdose Treatment** |
| Kloxxado |
| Naloxone (Cartridge, Injection, Nasal Spray & Prefilled Syringe) |
| Opvee |
| **Statins for High Cholesterol** |
| Atorvastatin (10mg, 20mg, 40mg & 80mg Tablet) |
| Lovastatin (10mg, 20mg & 40mg Tablet) |
| Simvastatin (5mg, 10mg, 20mg & 40mg Tablet) |
| **Tobacco Cessation Medications** |
| Bupropion (150mg Tablet SR) |
| Nicotrol (Nasal Spray) |
| Varenicline (0.5mg & 1mg Tablet) |

**You pay $0 for the drugs in the chart below.**

| **Diabetic Drugs** |
|---|
| Acarbose (25mg, 50mg, 100mg Tablet) |
| Dapagliflozin (5mg, 10mg Tablet) |
| Diazoxide (50mg/mL Suspension) |
| Glimepiride (1mg, 2mg, 4mg Tablet) |
| Glipizide (2.5mg, 5mg, 10mg, 15mg Tablet) |

| |
|---|
| Glipizide (2.5mg, 5mg, 10mg ER Tablet) |
| Glipizide/Metformin (2.5-250mg, 2.5-500mg, 5-500mg Tablet) |
| Glyburide (1.25mg, 2.5mg, 5mg Tablet) |
| Glyburide Micronized (1.5mg, 3mg, 6mg Tablet) |
| Glyburide/Metformin (1.25-250mg, 2.5-500mg, 5-500mg Tablet) |
| Metformin (500mg/5mL Solution) |
| Metformin (500mg, 850mg, 1000mg Tablet) |
| Metformin (500mg, 750mg ER Tablet) (Generic Glucophage XR) |
| Metformin (500mg, 1000mg ER 24 Hour Tablet) (Generic Fortamet) |
| Metformin (500mg, 1000mg ER 24 Hour Tablet) (Generic Glumetza) |
| Miglitol (25mg, 50mg, 100mg Tablet) |
| Nateglinide (60mg, 120mg Tablet) |
| Pioglitazone (15mg, 30mg, 45mg Tablet) |
| Pioglitazone/Glimepiride (30-2mg, 30-4mg Tablet) |
| Pioglitazone/Metformin (15-500mg, 15-850mg Tablet) |
| Repaglinide (0.5mg, 1mg, 2mg Tablet) |
| Saxagliptin (2.5mg, 5mg Tablet) |
| Saxagliptin/Metformin (2.5-1000mg, 5-500mg, 5-1000mg ER Tablet) |
| Sitagliptin (25mg, 50mg, 100mg Tablet) |
| Sitagliptin/Metformin (50-500mg, 50-1000mg Tablet) |

## You pay $25 for the drugs in the chart below.

| Diabetic Drugs |
|---|
| Glyxambi (Tablet) |
| Jardiance (Tablet) |
| Ozempic (Tablet) |
| Ozempic (Injection) |
| Synjardy (IR Tablet) |
| Synjardy (XR Tablet) |
| Trijardy (XR Tablet) |
| Trulicity (Injection) |
| Xigduo (XR Tablet) |

The amount you pay for these drugs counts towards your annual out-of-pocket maximum. Payments for these prescription drugs (made by you or the plan) are treated the same as payments made for drugs in your plan's Drug List. See the Evidence of Coverage (EOC) for information about the appeals and grievance process for these prescription drugs and supplies.

## You pay $0 for the following preventive drugs not typically covered by a Medicare Advantage plan.

These drugs are in addition to your plan's Drug List (Formulary). You will only find them listed here. You won't find them listed on your plan's Drug List.

| Colon Preparation Products |
|---|
| Bisacodyl (Tablet) |
| Bisacodyl (Suppository) |
| Magnesium Citrate (Solution) |
| Polyethylene Glycol (Powder) |
| **Blood Clot Prevention** |
| Aspirin (Generic Only) |

| Tobacco Cessation Medications |
|---|
| Nicotine (Gum) |
| Nicotine (Lozenges) |
| Nicotine (Patches) |
| **Vitamins** |
| Folic Acid (0.4mg, 0.8mg & 1mg Tablet) |

The amount you pay for these additional preventive drugs doesn't count towards your annual out-of-pocket maximum. You cannot file a Medicare appeal or grievance for these drugs.

**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** | | |
| **Alli** | 3 | PA, QL (maximum of 3 capsules per day) |
| Benzphetamine | 1 | PA, QL (maximum of 3 tablets per day) |
| **Contrave** | 3 | PA, QL (maximum of 4 tablets per day) |
| Diethylpropion (25 mg) | 1 | PA, QL (maximum of 3 tablets per day) |
| Diethylpropion (75 mg ER) | 1 | PA, QL (maximum of 1 tablet per day) |
| **Foundayo** | 4 | PA, QL (maximum of 1 tablet per day) |
| **Imcivree** | 3 | PA, QL (maximum of 9 vials (9 mL) per 30 days) |
| Liraglutide | 1 | PA, QL (maximum of 5 pens per 30 days) |
| Phendimetrazine (35 mg) | 1 | PA, QL (maximum of 6 tablets per day) |
| Phendimetrazine (105 mg ER) | 1 | PA, QL (maximum of 2 capsules per day) |
| Phentermine | 1 | PA, QL (maximum of 1 capsule/ tablet per day) |
| Phentermine/Topiramate | 1 | PA, QL (maximum of 1 capsule per day) |
| **Saxenda** | 4 | PA, QL (maximum of 5 pens per 30 days) |

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

| Drug name | Drug tier | Coverage rules or limits on use |
|---|---|---|
| **Wegovy** | 4 | PA, QL (maximum of 4 pens per 28 days) |
| **Zepbound** | 4 | PA, QL (maximum of 4 pens/vials per 28 days) |
| **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 | |
| **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** | | |

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

| Drug name | Drug tier | Coverage rules or limits on use |
|---|---|---|
| **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 & 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 | |
| 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 |

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

| Drug name | Drug tier | Coverage rules or limits on use |
|---|---|---|
| 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.

**PA - Prior Authorization**
The plan requires you or your doctor or prescriber to get prior approval for certain drugs. This means the plan needs more information from your doctor or prescriber to make sure the drug is being used and covered correctly for your medical condition.

**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.

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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.
- **I must continue to pay my FEHBP or PSHBP premium and not cancel or suspend my FEHBP or PSHBP coverage with the Office of Personnel Management (OPM), or I will be disenrolled from this Medicare Advantage plan.**
- **The service area includes the 50 United States, the District of Columbia and all U.S. territories.**
  I am covered both inside and outside the United States. Under this plan, all covered medical services and prescription drugs are covered worldwide the same as they are in the U.S., based on my plan benefits. If I receive care outside the U.S., I may need to pay up front and submit a claim for reimbursement.
- **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.
- **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.

## 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።

**ملاحظه**: إذا كنت تتحدث **اللغه العربيه (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 عضویت‌تان 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.

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**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.

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**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.

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**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.

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# Notes & doodles

# Notes & doodles

# Notes & doodles

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