



# 2026 Plan Guide

**13582 - Arkansas State Employees (ASE)**

**13583 - Public School Employees (PSE)**

ARBenefits Group Medicare Advantage (PPO) plan

**Group Number:** 13582, 13583

**Effective:** January 1, 2026 through December 31, 2026

United  
Healthcare®  
Group Medicare Advantage



# With the ARBenefits Group Medicare Advantage (PPO) Plan, you get more

The State of Arkansas has selected UnitedHealthcare to offer health care and prescription drug coverage for all Medicare-eligible retirees and their Medicare-eligible dependents. This is a special plan, only available to you as a retiree of Arkansas State and Public Schools. The ARBenefits Group Medicare Advantage (PPO) plan is a UnitedHealthcare® Group Medicare Advantage (PPO) plan that delivers all the benefits of Original Medicare (Parts A and B), includes prescription drug coverage (Part D), and offers additional benefits. As an ARBenefits Group Medicare Advantage plan member, you will have a team committed to understanding your needs and helping you get the right care.



## Read through this Plan Guide to get to know your 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. You can also get plan information at the website below. Use the Group Number on the front cover of this book to access plan materials online.



## How to enroll

Choose the ARBenefits Group MAPD PPO Plan on the Arkansas State & Public School Retiree Election Form. You can get this form from Employee Benefits Division (EBD) at [transform.ar.gov/employee-benefits/retirees](https://transform.ar.gov/employee-benefits/retirees) or call **1-877-815-1017**. Complete the Retiree Election Form and return it to EBD. They will forward your enrollment information to us.



## 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.



Visit [retiree.uhc.com/ARBenefits](https://retiree.uhc.com/ARBenefits) and select the **Chat now** button



Call toll-free **1-844-488-3953**, TTY **711**  
8 a.m.-8 p.m. local time, Monday-Friday

# More than health insurance

With this ARBenefits 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



**No medical deductible**



**Free standard gym membership** at participating locations



**\$0 copay** for preventive dental care including exams, cleanings, X-rays and fluoride.



**Free Optum® HouseCalls visit** from one of our licensed health care practitioners



**\$0 copay for an eye exam** every 12 months and \$150 allowance to spend on frames or \$150 for contact lenses every 12 months



**\$0 copay for a hearing exam** and \$2,800 allowance to spend on a broad selection of hearing aids for both ears every 3 years



**\$0 copay** for home-delivered meals, transportation to medical appointments and the pharmacy, and non-medical personal care to assist with daily activities after a hospital or skilled nursing facility stay



**Virtual doctor and behavioral health visits** using your computer, tablet or smartphone – anytime, day or night



**Earn rewards** to spend on eligible items like gifts, clothing, groceries and more



**A large network of providers** through our Medicare National Network



**Free delivery with Optum® Home Delivery Pharmacy** for prescriptions you take regularly\*



**Special programs to help you** if you are living with a chronic disease, like diabetes or heart disease, or other complex health needs



**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). Medicare has rules about what types of coverage you can add or combine with a group-sponsored Medicare Advantage plan.



## How the ARBenefits Group Medicare Advantage (PPO) plan works



**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**



**Select a primary care provider (PCP) to oversee and help manage your care**

It's not required by the plan, but it's very beneficial for your long-term health and well-being.



**You pay nothing for Medicare-covered services from any network or out-of-network provider**

We work closely with our network (contracted) providers to make sure they have access to resources and tools to help them work with you for better health outcomes.



**This plan has an annual out-of-pocket amount for prescription drugs**

After you and others on your behalf have paid a combined total of \$2,100 for your prescription drugs, you won't pay anything for your Medicare-covered Part D drugs for the rest of the calendar year.



**Emergency and urgently needed services are covered anywhere in the world**



**This plan includes prescription drug coverage for thousands of brand name and generic drugs, so you don't need to enroll in a separate Part D plan**

To search for a network provider or pharmacy, visit **[retiree.uhc.com/ARBenefits](https://retiree.uhc.com/ARBenefits)**. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

**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/ARBenefits](https://retiree.uhc.com/ARBenefits).



## Review the online Drug List 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](https://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.

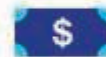
You may be disenrolled from this plan if you stop paying your Medicare Part B premium.



## 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 and enroll in another plan, you may not be able to re-enroll in this plan. Limitations and restrictions vary by former employer or plan sponsor.



# Summary of Benefits 2026

## **ARBenefits Group Medicare Advantage (PPO)**

Group Name (Plan Sponsor): Arkansas State Employees (ASE) and Public School Employees (PSE)

Group Number: 13582 and 13583

H2001-847-000

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



**[retiree.uhc.com/ARBenefits](https://retiree.uhc.com/ARBenefits)**



**Toll-free 1-844-488-3953, TTY 711**

8 a.m.-8 p.m. local time, Monday-Friday

**United  
Healthcare®**  
Group Medicare Advantage

Y0066\_SB\_H2001\_847\_000\_2026\_M

# Summary of Benefits

**January 1, 2026 - December 31, 2026**

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.

## ARBenefits Group Medicare Advantage (PPO)

| Medical premium 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.                                                                                                                                                                                                                                                                                  |
| Maximum out-of-pocket amount<br>(does not include prescription drugs) |                                  | <p>\$0 for Medicare-covered services from any provider</p> <p>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.</p> <p>Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.</p> |
| Medical benefits                                                      |                                  |                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                       |                                  | In-network and out-of-network                                                                                                                                                                                                                                                                                                                                                          |
| Inpatient hospital care <sup>1</sup>                                  |                                  | <p>\$0 copay per stay</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p>                                                                                                                                                                                                                                                                           |
| Outpatient hospital <sup>1</sup>                                      | Ambulatory surgical center (ASC) | \$0 copay                                                                                                                                                                                                                                                                                                                                                                              |
| Cost sharing for additional plan                                      | Outpatient surgery               | \$0 copay                                                                                                                                                                                                                                                                                                                                                                              |

| Medical benefits                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                             |
|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
|                                                                                                        | In-network and out-of-network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                             |
| covered services will apply.                                                                           | Outpatient hospital services, including observation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$0 copay                   |
|  <b>Doctor visits</b> | Primary care provider (PCP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | \$0 copay                   |
|                                                                                                        | Virtual visit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$0 copay                   |
|                                                                                                        | Specialist <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | \$0 copay                   |
| <b>Preventive services</b>                                                                             | Routine physical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$0 copay; 1 per plan year* |
|                                                                                                        | Medicare-covered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$0 copay                   |
|                                                                                                        | <div> <div> <ul style="list-style-type: none"> <li>□ Abdominal aortic aneurysm screening</li> <li>□ Alcohol misuse counseling</li> <li>□ Annual wellness visit</li> <li>□ Bone mass measurement</li> <li>□ Breast cancer screening (mammogram)</li> <li>□ Cardiovascular disease (behavioral therapy)</li> <li>□ Cardiovascular screening</li> <li>□ Cervical and vaginal cancer screening</li> <li>□ Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li>□ Depression screening</li> <li>□ Diabetes screenings and monitoring</li> <li>□ Diabetes – Self-Management training</li> <li>□ Dialysis training</li> <li>□ Glaucoma screening</li> <li>□ Hepatitis C screening</li> </ul> </div> <div> <ul style="list-style-type: none"> <li>□ HIV screening</li> <li>□ Kidney disease education</li> <li>□ Lung cancer with low dose computed tomography (LDCT) screening</li> <li>□ Medical nutrition therapy services</li> <li>□ Medicare Diabetes Prevention Program (MDPP)</li> <li>□ Obesity screenings and counseling</li> <li>□ Prostate cancer screenings (PSA)</li> <li>□ Sexually transmitted infections screenings and counseling</li> <li>□ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>□ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li> <li>□ “Welcome to Medicare” preventive visit (one-time)</li> </ul> </div> </div> |                             |

| Medical benefits                                                |                                                                                                                                                                                                |                                                                                                                                                                                                                                                                |
|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                 |                                                                                                                                                                                                | In-network and out-of-network                                                                                                                                                                                                                                  |
|                                                                 | <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> <p>This plan covers preventive care screenings and annual physical exams at 100%.</p> |                                                                                                                                                                                                                                                                |
| <b>Emergency care</b>                                           |                                                                                                                                                                                                | <p>\$0 copay (worldwide)</p> <p>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.</p>           |
| <b>Urgently needed services</b>                                 |                                                                                                                                                                                                | <p>\$0 copay (worldwide)</p> <p>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.</p> |
| <b>Diagnostic tests, lab and radiology services, and X-rays</b> | Diagnostic radiology services (e.g. MRI, CT scan) <sup>1</sup>                                                                                                                                 | \$0 copay                                                                                                                                                                                                                                                      |
|                                                                 | Lab services <sup>1</sup>                                                                                                                                                                      | \$0 copay                                                                                                                                                                                                                                                      |
|                                                                 | Diagnostic tests and procedures <sup>1</sup>                                                                                                                                                   | \$0 copay                                                                                                                                                                                                                                                      |
|                                                                 | Therapeutic radiology <sup>1</sup>                                                                                                                                                             | \$0 copay                                                                                                                                                                                                                                                      |
|                                                                 | Outpatient X-rays <sup>1</sup>                                                                                                                                                                 | \$0 copay                                                                                                                                                                                                                                                      |
| <b>Hearing services</b>                                         | Exam to diagnose and treat hearing and balance issues <sup>1</sup>                                                                                                                             | \$0 copay                                                                                                                                                                                                                                                      |
|                                                                 | Routine hearing exam                                                                                                                                                                           | \$0 copay, 1 exam per plan year*                                                                                                                                                                                                                               |
|                                                                 | Hearing Aids                                                                                                                                                                                   | The plan pays up to a \$2,800 allowance for hearing aids (combined for both ears) every 3 years.*                                                                                                                                                              |

## Medical benefits

|                                                                                                                                                                |                                                                            | In-network and out-of-network                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>Routine dental services</b><br>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)                       | \$0 copay, unlimited per plan year.                                                                                                                                                                                                                     |
|                                                                                                                                                                | Benefit limit                                                              | \$0 yearly deductible and \$500 combined in and out-of-network plan year 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. |
|  <b>Vision services</b>                                                      | Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup> | \$0 copay                                                                                                                                                                                                                                               |
|                                                                                                                                                                | Eyewear after cataract surgery                                             | \$0 copay                                                                                                                                                                                                                                               |
|                                                                                                                                                                | Routine eye exam                                                           | \$0 copay, 1 exam every 12 months*                                                                                                                                                                                                                      |
|                                                                                                                                                                | Routine eyewear                                                            | Plan pays up to \$150 for eyeglasses, or \$150 for contact lenses instead of eyeglasses, every 12 months.*                                                                                                                                              |

| Medical benefits                                                                                  |                                                                     |                                                                                                   |
|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
|                                                                                                   |                                                                     | In-network and out-of-network                                                                     |
| <b>Mental health</b>                                                                              | Inpatient visit <sup>1</sup>                                        | \$0 copay per stay<br>Our plan covers an unlimited number of days for an inpatient hospital stay. |
|                                                                                                   | Outpatient group therapy visit <sup>1</sup>                         | \$0 copay                                                                                         |
|                                                                                                   | Outpatient individual therapy visit <sup>1</sup>                    | \$0 copay                                                                                         |
|                                                                                                   | Outpatient therapy or office visit with a psychiatrist <sup>1</sup> | \$0 copay                                                                                         |
|                                                                                                   | Virtual behavioral visits                                           | \$0 copay                                                                                         |
| <b>Skilled nursing facility (SNF)<sup>1</sup></b>                                                 |                                                                     | \$0 copay per day: days 1-100<br>Our plan covers up to 100 days in a SNF per benefit period.      |
| <b>Outpatient Rehabilitation (physical, occupational, or speech/language therapy)<sup>1</sup></b> |                                                                     | \$0 copay                                                                                         |
| <b>Ambulance<sup>2</sup></b>                                                                      |                                                                     | \$0 copay                                                                                         |
| <b>Routine transportation</b>                                                                     |                                                                     | Not covered                                                                                       |
| <b>Medicare Part B Drugs</b>                                                                      | Chemotherapy drugs <sup>1</sup>                                     | \$0 copay                                                                                         |
|                                                                                                   | Other Part B drugs <sup>1</sup>                                     | \$0 copay                                                                                         |
| Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.           |                                                                     |                                                                                                   |
| Prescription drugs                                                                                |                                                                     |                                                                                                   |

|                                        |                                                                                                                                                                                                                                                                                                                                                       |                            |                                |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------|
| <b>Deductible</b>                      | This plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.                                                                                                                                                                                                                                           |                            |                                |
| <b>Initial Coverage</b>                | In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,100, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage.                                                                               |                            |                                |
| <b>Tier drug coverage</b>              | <b>Retail Cost-Sharing</b>                                                                                                                                                                                                                                                                                                                            | <b>Retail Cost-Sharing</b> | <b>Mail Order Cost-Sharing</b> |
|                                        | <b>31-day supply</b>                                                                                                                                                                                                                                                                                                                                  | <b>93-day supply</b>       | <b>93-day supply</b>           |
| <b>Tier 1:</b><br>Preferred Generic    | \$15 copay                                                                                                                                                                                                                                                                                                                                            | \$45 copay                 | \$30 copay                     |
| <b>Tier 2:</b><br>Preferred Brand ~    | \$40 copay                                                                                                                                                                                                                                                                                                                                            | \$120 copay                | \$80 copay                     |
| <b>Tier 3:</b><br>Non-Preferred Drug ~ | \$80 copay                                                                                                                                                                                                                                                                                                                                            | \$240 copay                | \$160 copay                    |
| <b>Tier 4:</b><br>Specialty Tier ~     | \$100 copay                                                                                                                                                                                                                                                                                                                                           | \$300 copay                | \$200 copay                    |
| <b>Catastrophic coverage</b>           | Once you're in this stage, you won't pay anything for your covered Part D drugs for the rest of the plan year.<br>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. 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/ARBenefits](https://retiree.uhc.com/ARBenefits) 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 31-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)                                                  | \$0 copay                                 |
|                       | Routine acupuncture services                                                                              | \$0 copay, up to 12 visits per plan year* |
| Chiropractic services | Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>1</sup> | \$0 copay                                 |
|                       | Routine chiropractic services                                                                             | \$0 copay, up to 15 visits per plan year* |

## Additional benefits

|                                                                                                                                                |                                                                               | In-network and out-of-network                                                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <b>Diabetes management</b>                                   | Diabetes monitoring supplies <sup>1</sup>                                     | <p>\$0 copay</p> <p>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.</p> <p>Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.</p> <p>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.</p>                                                      |
|                                                                                                                                                | Medicare covered Continuous Glucose Monitors (CGMs) and supplies <sup>1</sup> | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                | Diabetes self-management training                                             | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                | Therapeutic shoes or inserts <sup>1</sup>                                     | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Durable medical equipment (DME) and related supplies</b>                                                                                    | Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>1</sup>            | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                | Prosthetics (e.g., braces, artificial limbs) <sup>1</sup>                     | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                         |
|  <b>Fitness program</b><br>Renew Active by UnitedHealthcare |                                                                               | <p>\$0 copay for Renew Active by UnitedHealthcare, a Medicare fitness program. It includes a gym membership at a fitness location you select from our national network, plus online classes and fun activities outside of the gym, at no additional cost.</p> <p>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.</p> |

| Additional benefits                                                                                                                                 |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                     |                                                  | In-network and out-of-network                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Foot care (podiatry services)</b>                                                                                                                | Foot exams and treatment <sup>1</sup>            | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                     | Routine foot care                                | \$0 copay, 6 visits per plan year*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Over-the-counter (OTC) credit</b>                                                                                                                |                                                  | \$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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|  <b>UnitedHealthcare Healthy at Home</b><br>Post-discharge program |                                                  | \$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay: <ul style="list-style-type: none"> <li><input type="checkbox"/> 28 home-delivered meals, referral required</li> <li><input type="checkbox"/> 12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required</li> <li><input type="checkbox"/> 6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required</li> </ul> Services must be provided by approved vendors. Call Customer Service for more information, to request a referral after each discharge and to use your benefits. |
|  <b>Home health care<sup>1</sup></b>                             |                                                  | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Hospice</b>                                                                                                                                      |                                                  | You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Opioid treatment program services<sup>1</sup></b>                                                                                                |                                                  | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Outpatient substance use disorder services</b>                                                                                                   | Outpatient group therapy visit <sup>1</sup>      | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                     | Outpatient individual therapy visit <sup>1</sup> | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

| Additional benefits                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                          | In-network and out-of-network                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Diabetes Prevention and Weight Management Program</b> | <p>\$0 copay for Real Appeal®, an online weight management and healthy lifestyle program proven to help you achieve lifelong results.</p> <p>Call or go online to get started today. 1-844-924-7325, TTY 711 or <a href="http://uhc.realappeal.com">uhc.realappeal.com</a></p> <p>* Real Appeal is available at no additional cost to members with a BMI of 19 and higher. If you are pregnant, please speak with your primary care provider (PCP) before joining the program.</p> |
| <b>Renal dialysis<sup>1</sup></b>                        | \$0 copay                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

<sup>1</sup> 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.

<sup>2</sup> 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

ARBenefits 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 US territories.

## About providers and network pharmacies

ARBenefits 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/ARBenefits\*\*](https://retiree.uhc.com/ARBenefits) 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

ARBenefits 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](https://www.medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunice 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 tarjeta de ID de miembro 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 services, classes, activities 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.

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.

# Additional Drug Coverage

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

To see the complete Drug List, scan the QR code or visit [retiree.uhc.com/ARBenefits](https://retiree.uhc.com/ARBenefits)



## Lower-cost Medicare prescription drugs and supplies

The following drugs have a \$0 copay.

| Birth Control                                 | Tobacco Cessation Medications                      |
|-----------------------------------------------|----------------------------------------------------|
| (All oral contraceptives) (generic only)      | Bupropion (150mg Tablet SR)                        |
| Annovera (vaginal ring)                       | Nicotrol (Inhaler)                                 |
| Kyleena (intrauterine device)                 | Nicotrol (Nasal Spray)                             |
| Liletta (intrauterine device)                 | Varenicline (0.5mg, 1mg, & Starter Pack Tablets)   |
| Medroxyprogesterone (150mg/mL injection)      | Diabetes Medications                               |
| Mirena (intrauterine device)                  | Glimepiride (1mg Tablet)                           |
| Nexplanon (contraceptive implant)             | Glimepiride (2mg Tablet)                           |
| EluRyng (vaginal ring)                        | Glimepiride (4mg Tablet)                           |
| Haloette (vaginal ring)                       | Glipizide (5mg Tablet)                             |
| Skyla (intrauterine device)                   | Glipizide (10mg Tablet)                            |
| Xulane (patch)                                | Glipizide (ER & XL 2.5mg Tablet)                   |
| Zafemy (patch)                                | Glipizide (ER & XL 5mg Tablet)                     |
| Bowel Prep Products                           | Glipizide (ER & XL 10mg Tablet)                    |
| GaviLyte-C                                    | Metformin (500mg Tablet)                           |
| GaviLyte-G                                    | Metformin (850mg Tablet)                           |
| GaviLyte-N                                    | Metformin (1000mg Tablet)                          |
| PEG-3350/Electrolytes                         | Metformin (500mg ER Tablet)(generic Glucophage XR) |
| PEG-3350/NaCl/Na Bicarbonate/KCl              | Metformin (750mg ER Tablet)(generic Glucophage XR) |
| Breast Cancer Preventive Medications          | Repaglinide (0.5mg Tablet)                         |
| Raloxifene (60mg Tablet)                      | Repaglinide (1mg Tablet)                           |
| Tamoxifen (10mg & 20mg Tablet)                | Repaglinide (2mg Tablet)                           |
| Statins For High Cholesterol                  | Pioglitazone (15mg Tablet)                         |
| Atorvastatin (10mg, 20mg, 40mg & 80mg Tablet) | Pioglitazone (30mg Tablet)                         |
| Lovastatin (10mg, 20mg & 40mg Tablet)         | Pioglitazone (45mg Tablet)                         |
| Simvastatin (5mg, 10mg, 20mg & 40mg Tablet)   |                                                    |

See the Evidence of Coverage (EOC) for information about the appeals and grievance process for these prescription drugs and supplies.

### **Lower-cost non-Medicare prescription drugs**

The following drugs have a \$0 copay.

Your plan includes coverage for these preventive drugs that are not covered by a Medicare Advantage plan. They are covered in addition to, so not listed on, your plan's Drug List. The amount you pay for these additional preventive drugs don't count towards your annual out-of-pocket maximum. You cannot file a Medicare appeal or grievance for these drugs.

#### **Vitamins**

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Folic Acid (1mg Tablet)

## Bonus drug list

Your plan includes coverage for the following prescription drugs that are not listed on your plan's Drug List. Each drug is placed into a tier. See the Summary of Benefits for tier descriptions and costs.

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.

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

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

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

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

| Drug name                                                                                   | Drug tier | Coverage rules or limits on use |
|---------------------------------------------------------------------------------------------|-----------|---------------------------------|
| 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         |                                 |
| <b>Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions</b> |           |                                 |
| <b>Cough And Cold</b>                                                                       |           |                                 |
| Benzonatate (100 mg, 200 mg)                                                                | 1         |                                 |
| Brompheniramine/Pseudoephedrine/<br>Dextromethorphan (Syrup)                                | 1         |                                 |
| Guaifenesin/Codeine (Syrup)                                                                 | 1         | DL                              |
| Hydrocodone Polst/Chlorpheniramine (ER<br>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

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

### **QL - Quantity limits**

The plan will only cover 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's 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.

**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 make it easier to get the care you need, when and how you need it.



## You are here

UnitedHealthcare will process your enrollment



Create your account to review your plan online



Receive your member ID card in the mail



Coverage begins! Start using your plan

## Manage your plan online

If you haven't done so already, use your Medicare number or member ID number and email address to create an account at [retiree.uhc.com/ARBenefits](https://retiree.uhc.com/ARBenefits). Online you can:

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

## Once your coverage begins

- Schedule your annual wellness visit
- Get a yearly in-home visit with Optum® HouseCalls. Visit [UHCHouseCalls.com](https://UHCHouseCalls.com) 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

We'll send you an Annual Notice of Changes before your plan year ends that will tell you about any changes to your plan for the next plan 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 member ID card 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.

# Statements of understanding

By enrolling in this ARBenefits Group Medicare Advantage (PPO) Plan, I agree to the following:

- ✓ **This is a Medicare Advantage Group (PPO) 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 ARBenefits Group Medicare Advantage (PPO) Plan.
  - If I disenroll from this plan, I will be unable to continue benefits with ARBenefits Group Medicare Advantage (PPO) Plan.
  - Enrollment in this plan is for the entire plan year. I may disenroll from this plan during ARBenefits Retiree Open Enrollment 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 when my coverage begins, I will receive all 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 nondiscrimination

Our Companies comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call the toll-free number on your member identification card (TTY **711**).

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UT 84130  
**UHC\_Civil\_Rights@uhc.com**

Optum Civil Rights Coordinator  
1 Optum Circle  
Eden Prairie, MN 55344  
**Optum\_Civil\_Rights@Optum.com**

If you need help filing a complaint, call the toll-free number on your member identification card (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**  
Phone: **1-800-368-1019, 800-537-7697** (TDD)  
Mail: U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

Complaint forms are available at: **<http://www.hhs.gov/ocr/office/file/index.html>**.

This notice is available at: **<https://www.uhc.com/nondiscrimination-med>**  
**<https://www.optum.com/en/language-assistance-nondiscrimination.html>**

## 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 قالب‌های 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.

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

**ATENSIÓN:** 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ヤ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

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