



# Annual Notice of Change 2026

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

Group Name (Plan Sponsor): Colorado PERA Medicare Advantage # 2

Group Number: 15704



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



**Toll-free 1-844-280-7754, TTY 711**

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

**Do we have the right address for you?**

If not, please let us know so we can keep you informed about your plan.

**United  
Healthcare®**

# Find updates to your plan for next year

This notice provides information about updates to your plan, but it doesn't include all of the details. Throughout this notice you will be directed to **retiree.uhc.com/peracare** to review the details online, which are available anytime.

## Provider Directory

Review the 2026 Provider Directory online to make sure your providers (primary care provider, specialists, hospitals, etc.) will be in the network next year.

## Pharmacy Directory

Review the 2026 Pharmacy Directory online to see which pharmacies are in our network next year.

## Drug List (Formulary)

You can look up which drugs will be covered by your plan next year and review any new restrictions on our website.

## Evidence of Coverage (EOC)

Review your 2026 EOC for details about plan costs and benefits. The EOC is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. It also has information about the quality program, how medical coverage decisions are made and your Rights and Responsibilities as a member. You can also find information about your additional prescription drug coverage in your Additional Drug Coverage list and the **Certificate of Coverage**.

## Reduce the clutter and get plan materials faster.

Visit **retiree.uhc.com/peracare** to sign up for paperless delivery.

## Would you rather get paper copies?

If you want a paper copy of what is listed above, contact our Customer Service at 1-844-280-7754 (TTY users should call 711). Hours are 8 a.m.-8 p.m. local time, Monday-Friday.

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

# Annual Notice of Change for the 2026 plan year



**You're enrolled as a member of UnitedHealthcare® Group Medicare Advantage (PPO).**

This material describes changes to our plan's costs and benefits next plan year.

You can make plan changes during Open Enrollment from October 20 - November 20, 2025.

## More Resources

- 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 materials in other languages, braille, large print, audio, or you can ask for an interpreter. Call us toll-free at the number on your member ID card or the front of your plan booklet.
- UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comuniquen con nosotros. Por ejemplo, materiales en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Llámenos al número gratuito que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

## About UnitedHealthcare® Group Medicare Advantage (PPO)

- Plans are 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.
- When this material says "we," "us," or "our," it means UnitedHealthcare Insurance Company or one of its affiliates. When it says "plan" or "our plan," it means UnitedHealthcare® Group Medicare Advantage (PPO).

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- **If you do nothing, you'll automatically be enrolled in UnitedHealthcare® Group Medicare Advantage (PPO).** Starting January 1, 2026, you'll get your medical and drug coverage through UnitedHealthcare® Group Medicare Advantage (PPO). Go to Section 3 for more information about how to change plans and deadlines for making a change.

# Annual Notice of Change for 2026

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## Summary of important costs for 2026

|                                                                                                                                                                                                                                                                                                                                          | 2025 (this plan year)                                                                                                                                                                                            | 2026 (next plan year)                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Maximum out-of-pocket amounts</b><br><br>This is the <b>most</b> you'll pay out-of-pocket for covered Part A and Part B services.<br><br>(Go to Section 1.2 for details.)                                                                                                                                                             | Your plan has 2 annual service-specific out-of-pocket maximum amounts. The Inpatient services amount is \$1,500 and the Total amount is \$6,000.                                                                 | From in-network and out-of-network providers combined: \$3,500                                                                                                                                                                                     |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                                                                                        | You pay a \$20 copayment per visit (in-network).<br><br>You pay a \$20 copayment per visit (out-of-network).                                                                                                     | You pay a \$5 copayment per visit (in-network).<br><br>You pay a \$5 copayment per visit (out-of-network).                                                                                                                                         |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                                                                                          | You pay a \$30 copayment per visit (in-network).<br><br>You pay a \$30 copayment per visit (out-of-network).                                                                                                     | You pay a \$40 copayment per visit (in-network).<br><br>You pay a \$40 copayment per visit (out-of-network).                                                                                                                                       |
| <b>Inpatient hospital stays</b><br><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. | You pay a \$500 copayment for each Medicare-covered hospital stay for unlimited days (in-network).<br><br>You pay a \$500 copayment for each Medicare-covered hospital stay for unlimited days (out-of-network). | You pay a \$200 copayment each day for days 1 to 10 (in-network).<br><br>\$0 copayment for additional Medicare covered days each day for unlimited days (in-network).<br><br>You pay a \$200 copayment each day for days 1 to 10 (out-of-network). |



**Questions?** Call Customer Service at **1-844-280-7754**, TTY **711**, 8 a.m.-8 p.m. local time, Monday-Friday

|                                                                                                                                                  | 2025 (this plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2026 (next plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | \$0 copayment for additional Medicare covered days each day for unlimited days (out-of-network).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Part D drug coverage deductible</b><br>(Go to Section 1.7 for details.)                                                                       | Because we have no deductible, this payment stage doesn't apply to you.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | \$300, except for covered insulin products and most adult Part D vaccines.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Part D drug coverage</b><br>(Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) | <p>Copays/Coinsurance for a one-month (31-day) supply during the Initial Coverage stage:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: Standard retail cost-sharing (in-network) \$15 copayment</li> <li>• Drug Tier 2: Standard retail cost-sharing (in-network) \$45 copayment<br/>You pay \$35 per month supply of each covered insulin product on this tier<sup>1</sup>.</li> <li>• Drug Tier 3: Standard retail cost-sharing (in-network) \$60 copayment<br/>You pay \$35 per month supply of each covered insulin product on this tier<sup>1</sup>.</li> </ul> | <p>Copays/Coinsurance for a one-month (31-day) supply during the Initial Coverage stage:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: Standard retail cost-sharing (in-network) \$15 copayment</li> <li>• Drug Tier 2: Standard retail cost-sharing (in-network) \$45 copayment<br/>You pay \$35 per month supply of each covered insulin product on this tier<sup>1</sup>.</li> <li>• Drug Tier 3: Standard retail cost-sharing (in-network) \$60 copayment<br/>You pay \$35 per month supply of each covered insulin product on this tier<sup>1</sup>.</li> </ul> |



**Questions?** Call Customer Service at **1-844-280-7754**, TTY **711**, 8 a.m.-8 p.m. local time, Monday-Friday

|  | 2025 (this plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2026 (next plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <ul style="list-style-type: none"><li>• Drug Tier 4: Standard retail cost-sharing (in-network) \$75 copayment</li></ul> <p>You pay \$35 per month supply of each covered insulin product on this tier<sup>1</sup>.</p> <p>Catastrophic Coverage Stage:</p> <ul style="list-style-type: none"><li>• During this payment stage, you pay nothing for your covered Part D drugs.</li><li>• You can have cost sharing for additional drugs that are covered under our enhanced benefit.</li></ul> | <ul style="list-style-type: none"><li>• Drug Tier 4: Standard retail cost-sharing (in-network) \$75 copayment</li></ul> <p>You pay \$35 per month supply of each covered insulin product on this tier<sup>1</sup>.</p> <p>Catastrophic Coverage Stage:</p> <ul style="list-style-type: none"><li>• During this payment stage, you pay nothing for your covered Part D drugs.</li><li>• You can have cost sharing for additional drugs that are covered under our enhanced benefit.</li></ul> |

<sup>1</sup> You will pay a maximum of \$35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven’t paid your Part D deductible.

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## Section 1 Changes to Benefits & Costs for Next Plan Year

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### Section 1.1 Changes to the Monthly Plan Premium

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Your plan sponsor will notify you of any changes to your plan premium amount, if applicable.

### Section 1.2 Changes to Your Maximum Out-of-Pocket Amounts

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Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the plan year.

|                                                                                                                                                                                                                                                                                                                                                     | 2025 (this plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 2026 (next plan year)                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Combined maximum out-of-pocket amount</b><br><br>Your costs for covered medical services (such as copayments) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Our plan premium and costs for prescription drugs don't count toward your maximum out-of-pocket amount for medical services. | <p>Your Total combined out-of-pocket maximum is \$6,000. There is a separate \$1,500 maximum out-of-pocket amount for inpatient hospital care. Amounts paid toward the \$1,500 Inpatient services amount also apply to the \$6,000 Total amount.</p> <p>Once you've paid \$1,500 out-of-pocket for Inpatient services the plan will cover these services at no cost to you for the rest of the plan year. If you've paid \$6,000 for covered services, you will not pay anything for covered services for the rest of the plan year.</p> <p>See your EOC to find out what's included in each out-of-pocket maximum category.</p> | <p>\$3,500</p> <p>Once you've paid \$3,500 out-of-pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the plan year.</p> |

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### Section 1.3 Changes to the Provider Network

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Our network of providers has changed for next plan year. Review the 2026 Provider Directory ([retiree.uhc.com/peracare](https://retiree.uhc.com/peracare)) to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Because you are a member of the UnitedHealthcare Group Medicare Advantage (PPO) plan, **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.** Here's how to get an updated Provider Directory:

- Visit our website at [retiree.uhc.com/peracare](https://retiree.uhc.com/peracare).
- Call Customer Service at 1-844-280-7754 (TTY users call 711) to get current provider information or to ask us to mail you a Provider Directory.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the plan year. If a mid-year change in our providers affects you, call Customer Service at 1-844-280-7754 (TTY users call 711) for help.

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### Section 1.4 Changes to the Pharmacy Network

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Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Our network of pharmacies has changed for next plan year. Review the 2026 Pharmacy Directory ([retiree.uhc.com/peracare](https://retiree.uhc.com/peracare)) to see which pharmacies are in our network. Here's how to get an updated Pharmacy Directory:

- Visit our website at [retiree.uhc.com/peracare](https://retiree.uhc.com/peracare).
- Call Customer Service at 1-844-280-7754 (TTY users call 711) to get current pharmacy information or to ask us to mail you a Pharmacy Directory.

We can make changes to the pharmacies that are part of our plan during the plan year. If a mid-year change in our pharmacies affects you, call Customer Service at 1-844-280-7754 (TTY users call 711) for help.

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### Section 1.5 Changes to Benefits & Costs for Medical Services

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|                                                                 | 2025 (this plan year)                                                       | 2026 (next plan year)                                                                                                                               |
|-----------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Plan year benefits</b>                                       | The plan's coverage begins January 1, 2025.                                 | The plan's coverage begins January 1, 2026.<br><br>Please see your Evidence of Coverage for information on benefits and costs for medical services. |
| <b>Acupuncture for chronic low back pain (Medicare-covered)</b> | You pay a \$15 copayment (in-network)                                       | You pay a \$40 copayment (in-network)<br><br>See Chapter 4 of the Evidence of Coverage for details.                                                 |
| <b>Acupuncture for chronic low back pain (Medicare-covered)</b> | You pay a \$15 copayment (out-of-network)                                   | You pay a \$40 copayment (out-of-network)<br><br>See Chapter 4 of the Evidence of Coverage for details.                                             |
| <b>Additional routine podiatry</b>                              | You pay a \$30 copayment for each routine foot care visit (in-network).     | You pay a \$40 copayment for each routine foot care visit (in-network).                                                                             |
| <b>Additional routine podiatry</b>                              | You pay a \$30 copayment for each routine foot care visit (out-of-network). | You pay a \$40 copayment for each routine foot care visit (out-of-network).                                                                         |
| <b>Ambulance services</b>                                       | You pay a \$100 copayment.                                                  | You pay a \$150 copayment.                                                                                                                          |
| <b>Cardiac rehabilitation</b>                                   | You pay a \$30 copayment (in-network).                                      | You pay a \$50 copayment (in-network).                                                                                                              |
| <b>Cardiac rehabilitation</b>                                   | You pay a \$30 copayment (out-of-network).                                  | You pay a \$50 copayment (out-of-network).                                                                                                          |

|                                           | 2025 (this plan year)                                                                                                                                    | 2026 (next plan year)                      |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| <b>Cardiac rehabilitation - intensive</b> | You pay a \$30 copayment (in-network).                                                                                                                   | You pay a \$50 copayment (in-network).     |
| <b>Cardiac rehabilitation - intensive</b> | You pay a \$30 copayment (out-of-network).                                                                                                               | You pay a \$50 copayment (out-of-network). |
| <b>Chiropractic services</b>              | You pay a \$15 copayment (in-network).                                                                                                                   | You pay a \$20 copayment (in-network).     |
| <b>Chiropractic services</b>              | You pay a \$15 copayment (out-of-network).                                                                                                               | You pay a \$20 copayment (out-of-network). |
| <b>Routine chiropractic services</b>      | You pay a \$15 copayment per visit for routine chiropractic visits. You are covered up to 12 visits per year. Benefit is combined in and out-of-network. | Not covered.                               |

|                                                                                                             | 2025 (this plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2026 (next plan year)                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Chronic care management services, including chronic pain management and treatment plan services</b>      | <p>This section did not exist in your 2025 Evidence of Coverage.</p> <p>If you have serious chronic conditions and receive chronic care management services, your provider develops a monthly comprehensive care plan that lists your health problems and goals, providers, medications, community services you have and need, and other information about your health. Your provider also helps coordinate your care when you go from one health care setting to another.</p> | <p>What you pay depends on who provides your chronic care management services. You will pay the cost-sharing that applies for services provided by your primary care provider, specialist, nurse practitioner, physician's assistant, or other non-physician health care professional.</p> <p>View the Evidence of Coverage for your specific cost-share amounts.</p> |
| <b>Diabetes Prevention and Weight Management Program</b>                                                    | Covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Not covered.                                                                                                                                                                                                                                                                                                                                                          |
| <b>Diabetes self-management training, diabetic services and supplies<br/>- Diabetes monitoring supplies</b> | <p>You pay a \$0 copayment (in-network).</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include:<br/>OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-</p>                                                                                                                                                               | <p>You pay a \$0 copayment (in-network).</p> <p>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.</p> <p>Covered glucose monitors include:<br/>Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.</p>                                                             |

|                                                                                                                   | 2025 (this plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 2026 (next plan year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                   | <p>Chek® Aviva Plus and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan. If you use a brand of supplies that is not covered by your plan, you should speak with your doctor to get a new prescription for a covered brand.</p>                                                                                                                                                                                                                                                                                                              | <p>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.</p> <p>If you use a brand of supplies that is not covered by your plan, you should speak with your provider to get a new prescription for a covered brand.</p>                                                                                                                                                                                                                                                                                                               |
| <b>Diabetes self-management training, diabetic services and supplies</b><br><b>- Diabetes monitoring supplies</b> | <p>You pay a \$0 copayment (out-of-network).</p> <p>We only cover Accu-Chek® and OneTouch® brands.</p> <p>Covered glucose monitors include:<br/>OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide.</p> <p>Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView.</p> <p>Other brands are not covered by your plan. If you use a brand of supplies that is not covered by your plan, you should speak with your doctor to get a new prescription for a covered brand.</p> | <p>You pay a \$0 copayment (out-of-network).</p> <p>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.</p> <p>Covered glucose monitors include:<br/>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> <p>If you use a brand of supplies that is not covered by your plan, you should speak with your provider to get a new prescription for a covered brand.</p> |

|                                                                                              | 2025 (this plan year)                                                                                                                | 2026 (next plan year)                                                                                                                |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                              |                                                                                                                                      | prescription for a covered brand.                                                                                                    |
| <b>Diabetes self-management training, diabetic services and supplies - therapeutic shoes</b> | You pay a \$0 copayment (in-network).                                                                                                | You pay a \$25 copayment (in-network).                                                                                               |
| <b>Diabetes self-management training, diabetic services and supplies - therapeutic shoes</b> | You pay a \$0 copayment (out-of-network).                                                                                            | You pay a \$25 copayment (out-of-network).                                                                                           |
| <b>Durable medical equipment and related supplies</b>                                        | You pay 20% of the total cost (in-network).                                                                                          | You pay a \$25 copayment (in-network).                                                                                               |
| <b>Durable medical equipment and related supplies</b>                                        | You pay 20% of the total cost (out-of-network).                                                                                      | You pay a \$25 copayment (out-of-network).                                                                                           |
| <b>Emergency care</b>                                                                        | You are not required to pay the emergency care copayment if you are admitted to the hospital within 72 hours for the same condition. | You are not required to pay the emergency care copayment if you are admitted to the hospital within 24 hours for the same condition. |
| <b>Emergency care</b>                                                                        | You pay a \$65 copayment.                                                                                                            | You pay a \$100 copayment.                                                                                                           |
| <b>Emergency care – worldwide</b>                                                            | You pay a \$65 copayment.                                                                                                            | You pay a \$100 copayment.                                                                                                           |
| <b>Hearing services</b><br>Medicare-covered hearing and balance exams                        | You pay a \$30 copayment (in-network).                                                                                               | You pay a \$40 copayment (in-network).                                                                                               |
| <b>Hearing services</b><br>Medicare-covered hearing and balance exams                        | You pay a \$30 copayment (out-of-network).                                                                                           | You pay a \$40 copayment (out-of-network).                                                                                           |

|                                         | 2025 (this plan year)                                                                                                                               | 2026 (next plan year)                                                                                                                                                                                                                                     |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hearing services</b><br>Hearing aids | You receive a \$500 allowance (combined for both ears) for hearing aids every 3 years from any provider. Benefit is combined in and out-of-network. | Through UnitedHealthcare Hearing, you receive a \$500 allowance (combined for both ears) for hearing aids every 3 years (in-network).<br><br>Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered (out-of-network). |
| <b>Inpatient hospital care</b>          | You pay a \$500 copayment for each Medicare-covered hospital stay for unlimited days (in-network).                                                  | You pay a \$200 copayment each day for days 1 to 10 (in-network).<br><br>\$0 copayment for additional Medicare covered days each day for unlimited days (in-network).                                                                                     |
| <b>Inpatient hospital care</b>          | You pay a \$500 copayment for each Medicare-covered hospital stay for unlimited days (out-of-network).                                              | You pay a \$200 copayment each day for days 1 to 10 (out-of-network).<br><br>\$0 copayment for additional Medicare covered days each day for unlimited days (out-of-network).                                                                             |
| <b>Inpatient mental health care</b>     | You pay a \$500 copayment for each Medicare-covered hospital stay for unlimited days (in-network).                                                  | You pay a \$175 copayment each day for days 1 to 8 (in-network).<br><br>\$0 copayment each day for days 9 to 190, up to 190 days (in-network).                                                                                                            |

|                                                                                              | 2025 (this plan year)                                                                                  | 2026 (next plan year)                                                                                                                                  |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient mental health care</b>                                                          | You pay a \$500 copayment for each Medicare-covered hospital stay for unlimited days (out-of-network). | You pay a \$175 copayment each day for days 1 to 8 (out-of-network).<br><br>\$0 copayment each day for days 9 to 190, up to 190 days (out-of-network). |
| <b>Medicare Part B prescription drugs</b>                                                    | You pay a \$0 copayment (in-network).                                                                  | You pay a \$50 copayment (in-network).                                                                                                                 |
| <b>Medicare Part B prescription drugs</b>                                                    | You pay a \$0 copayment (out-of-network).                                                              | You pay a \$50 copayment (out-of-network).                                                                                                             |
| <b>Medicare Part B prescription drugs - chemotherapy drugs</b>                               | You pay a \$0 copayment (in-network).                                                                  | You pay a \$50 copayment (in-network).                                                                                                                 |
| <b>Medicare Part B prescription drugs - chemotherapy drugs</b>                               | You pay a \$0 copayment (out-of-network).                                                              | You pay a \$50 copayment (out-of-network).                                                                                                             |
| <b>Medicare Part B prescription drugs - covered insulin</b>                                  | You pay a \$0 copayment (in-network).                                                                  | You pay a \$35 copayment (in-network).                                                                                                                 |
| <b>Medicare Part B prescription drugs - covered insulin</b>                                  | You pay a \$0 copayment (out-of-network).                                                              | You pay a \$35 copayment (out-of-network).                                                                                                             |
| <b>Outpatient diagnostic tests and therapeutic services and supplies – medical supplies</b>  | You pay 20% of the total cost (in-network).                                                            | You pay a \$25 copayment (in-network).                                                                                                                 |
| <b>Outpatient diagnostic tests and therapeutic services and supplies – medical supplies</b>  | You pay 20% of the total cost (out-of-network).                                                        | You pay a \$25 copayment (out-of-network).                                                                                                             |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - radiation therapy</b> | You pay a \$30 copayment (in-network).                                                                 | You pay a \$40 copayment (in-network).                                                                                                                 |

|                                                                                                                                                           | 2025 (this plan year)                       | 2026 (next plan year)                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------|
| <b>Outpatient diagnostic tests and therapeutic services and supplies - radiation therapy</b>                                                              | You pay a \$30 copayment (out-of-network).  | You pay a \$40 copayment (out-of-network). |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - X-rays</b>                                                                         | You pay a \$20 copayment (in-network).      | You pay a \$40 copayment (in-network).     |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - X-rays</b>                                                                         | You pay a \$20 copayment (out-of-network).  | You pay a \$40 copayment (out-of-network). |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - non-radiological diagnostic services</b>                  | You pay a \$20 copayment (in-network).      | You pay a \$40 copayment (in-network).     |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - non-radiological diagnostic services</b>                  | You pay a \$20 copayment (out-of-network).  | You pay a \$40 copayment (out-of-network). |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - radiological diagnostic service, not including X-rays</b> | You pay a \$100 copayment (in-network).     | You pay a \$40 copayment (in-network).     |
| <b>Outpatient diagnostic tests and therapeutic services and supplies - other diagnostic tests - radiological diagnostic service, not including X-rays</b> | You pay a \$100 copayment (out-of-network). | You pay a \$40 copayment (out-of-network). |
| <b>Outpatient dialysis treatment</b>                                                                                                                      | You pay a \$20 copayment (in-network).      | You pay a \$0 copayment (in-network).      |
| <b>Outpatient dialysis treatment</b>                                                                                                                      | You pay a \$20 copayment (out-of-network).  | You pay a \$0 copayment (out-of-network).  |

|                                                                                                       | 2025 (this plan year)                      | 2026 (next plan year)                      |
|-------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------|
| <b>Outpatient mental health care - group therapy session</b>                                          | You pay a \$30 copayment (in-network).     | You pay a \$40 copayment (in-network).     |
| <b>Outpatient mental health care - group therapy session</b>                                          | You pay a \$30 copayment (out-of-network). | You pay a \$40 copayment (out-of-network). |
| <b>Outpatient mental health care - individual therapy session</b>                                     | You pay a \$30 copayment (in-network).     | You pay a \$40 copayment (in-network).     |
| <b>Outpatient mental health care - individual therapy session</b>                                     | You pay a \$30 copayment (out-of-network). | You pay a \$40 copayment (out-of-network). |
| <b>Outpatient mental health care - therapy session or office visit with a psychiatrist</b>            | You pay a \$30 copayment (in-network).     | You pay a \$40 copayment (in-network).     |
| <b>Outpatient mental health care - therapy session or office visit with a psychiatrist</b>            | You pay a \$30 copayment (out-of-network). | You pay a \$40 copayment (out-of-network). |
| <b>Outpatient rehabilitation services - comprehensive outpatient rehabilitation facilities (CORF)</b> | You pay a \$20 copayment (in-network).     | You pay a \$50 copayment (in-network).     |
| <b>Outpatient rehabilitation services - comprehensive outpatient rehabilitation facilities (CORF)</b> | You pay a \$20 copayment (out-of-network). | You pay a \$50 copayment (out-of-network). |
| <b>Outpatient rehabilitation services - occupational therapy</b>                                      | You pay a \$20 copayment (in-network).     | You pay a \$50 copayment (in-network).     |
| <b>Outpatient rehabilitation services - occupational therapy</b>                                      | You pay a \$20 copayment (out-of-network). | You pay a \$50 copayment (out-of-network). |
| <b>Outpatient rehabilitation services - physical therapy and speech therapy</b>                       | You pay a \$20 copayment (in-network).     | You pay a \$50 copayment (in-network).     |

|                                                                                                                       | 2025 (this plan year)                      | 2026 (next plan year)                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Outpatient rehabilitation services - physical therapy and speech therapy</b>                                       | You pay a \$20 copayment (out-of-network). | You pay a \$50 copayment (out-of-network).                                                                                                                                                                                                                                                               |
| <b>Outpatient substance use disorder services - group therapy sessions</b>                                            | You pay a \$30 copayment (in-network).     | You pay a \$40 copayment (in-network).                                                                                                                                                                                                                                                                   |
| <b>Outpatient substance use disorder services - group therapy sessions</b>                                            | You pay a \$30 copayment (out-of-network). | You pay a \$40 copayment (out-of-network).                                                                                                                                                                                                                                                               |
| <b>Outpatient substance use disorder services - individual therapy sessions</b>                                       | You pay a \$30 copayment (in-network).     | You pay a \$40 copayment (in-network).                                                                                                                                                                                                                                                                   |
| <b>Outpatient substance use disorder services - individual therapy sessions</b>                                       | You pay a \$30 copayment (out-of-network). | You pay a \$40 copayment (out-of-network).                                                                                                                                                                                                                                                               |
| <b>Partial hospitalization and intensive outpatient services</b>                                                      | You pay a \$30 copayment (in-network).     | You pay a \$55 copayment (in-network).                                                                                                                                                                                                                                                                   |
| <b>Partial hospitalization and intensive outpatient services</b>                                                      | You pay a \$30 copayment (out-of-network). | You pay a \$55 copayment (out-of-network).                                                                                                                                                                                                                                                               |
| <b>Personal emergency response system (PERS)</b>                                                                      | Covered                                    | Not covered. PERS devices will no longer be covered under the plan. However, members of the plan are eligible for a discount on PERS devices with Lifeline starting in 2026. For more information, call the Lifeline Care Concierge Team at 1-800-686-2168, TTY 711, 8 a.m.–8:30 p.m. ET, Monday–Friday. |
| <b>Physician/practitioner services, including doctor's office visits - Medicare-covered hearing and balance exams</b> | You pay a \$30 copayment (in-network).     | You pay a \$40 copayment (in-network).                                                                                                                                                                                                                                                                   |

|                                                                                                                                                                                                                                                                                                  | 2025 (this plan year)                                                  | 2026 (next plan year)                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <b>Physician/practitioner services, including doctor's office visits - Medicare-covered hearing and balance exams</b>                                                                                                                                                                            | You pay a \$30 copayment (out-of-network).                             | You pay a \$40 copayment (out-of-network).                            |
| <b>Physician/practitioner services, including doctor's office visits - non-routine dental care</b>                                                                                                                                                                                               | You pay a \$30 copayment (in-network).                                 | You pay a \$40 copayment (in-network).                                |
| <b>Physician/practitioner services, including doctor's office visits - non-routine dental care</b>                                                                                                                                                                                               | You pay a \$30 copayment (out-of-network).                             | You pay a \$40 copayment (out-of-network).                            |
| <b>Physician/practitioner services, including doctor's office visits - primary care provider</b>                                                                                                                                                                                                 | You pay a \$20 copayment (in-network).                                 | You pay a \$5 copayment (in-network).                                 |
| <b>Physician/practitioner services, including doctor's office visits - primary care provider</b>                                                                                                                                                                                                 | You pay a \$20 copayment (out-of-network).                             | You pay a \$5 copayment (out-of-network).                             |
| <b>Physician/practitioner services, including doctor's office visits - specialists</b>                                                                                                                                                                                                           | You pay a \$30 copayment (in-network).                                 | You pay a \$40 copayment (in-network).                                |
| <b>Physician/practitioner services, including doctor's office visits - specialists</b>                                                                                                                                                                                                           | You pay a \$30 copayment (out-of-network).                             | You pay a \$40 copayment (out-of-network).                            |
| <b>Physician/practitioner services, including doctor's office visits – telehealth</b><br><br>Certain telehealth services including consultation, monitoring, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare | You pay a \$20 copayment for each Medicare-covered visit (in-network). | You pay a \$0 copayment for each Medicare-covered visit (in-network). |

|                                                                                                                                                                                                                                                                                                  | 2025 (this plan year)                                                      | 2026 (next plan year)                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <b>Physician/practitioner services, including doctor's office visits – telehealth</b><br><br>Certain telehealth services including consultation, monitoring, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare | You pay a \$20 copayment for each Medicare-covered visit (out-of-network). | You pay a \$0 copayment for each Medicare-covered visit (out-of-network). |
| <b>Podiatry services</b>                                                                                                                                                                                                                                                                         | You pay a \$30 copayment (in-network).                                     | You pay a \$40 copayment (in-network).                                    |
| <b>Podiatry services</b>                                                                                                                                                                                                                                                                         | You pay a \$30 copayment (out-of-network).                                 | You pay a \$40 copayment (out-of-network).                                |
| <b>Prosthetic devices and related supplies - orthotics</b>                                                                                                                                                                                                                                       | You pay 20% of the total cost (in-network).                                | You pay a \$25 copayment (in-network).                                    |
| <b>Prosthetic devices and related supplies - orthotics</b>                                                                                                                                                                                                                                       | You pay 20% of the total cost (out-of-network).                            | You pay a \$25 copayment (out-of-network).                                |
| <b>Prosthetic devices and related supplies - prosthetics</b>                                                                                                                                                                                                                                     | You pay 20% of the total cost (in-network).                                | You pay a \$25 copayment (in-network).                                    |
| <b>Prosthetic devices and related supplies - prosthetics</b>                                                                                                                                                                                                                                     | You pay 20% of the total cost (out-of-network).                            | You pay a \$25 copayment (out-of-network).                                |
| <b>Pulmonary rehabilitation</b>                                                                                                                                                                                                                                                                  | You pay a \$15 copayment (in-network).                                     | You pay a \$35 copayment (in-network).                                    |
| <b>Pulmonary rehabilitation</b>                                                                                                                                                                                                                                                                  | You pay a \$15 copayment (out-of-network).                                 | You pay a \$35 copayment (out-of-network).                                |
| <b>Skilled nursing facility (SNF) care</b>                                                                                                                                                                                                                                                       | You pay a \$0 copayment each day for days 1 to 20 (in-network).            | You pay a \$20 copayment each day for days 1 to 20 (in-network).          |

|                                             | 2025 (this plan year)                                                                                                                                                  | 2026 (next plan year)                                                                                                                                      |
|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                             | You pay a \$75 copayment each day for days 21 to 100 (in-network).                                                                                                     | You pay a \$100 copayment each day for days 21 to 100 (in-network).                                                                                        |
| <b>Skilled nursing facility (SNF) care</b>  | <p>You pay a \$0 copayment each day for days 1 to 20 (out-of-network).</p> <p>You pay a \$75 copayment each day for days 21 to 100 (out-of-network).</p>               | <p>You pay a \$20 copayment each day for days 1 to 20 (out-of-network).</p> <p>You pay a \$100 copayment each day for days 21 to 100 (out-of-network).</p> |
| <b>Supervised exercise therapy (SET)</b>    | You pay a \$25 copayment (in-network).                                                                                                                                 | You pay a \$30 copayment (in-network).                                                                                                                     |
| <b>Supervised exercise therapy (SET)</b>    | You pay a \$25 copayment (out-of-network).                                                                                                                             | You pay a \$30 copayment (out-of-network).                                                                                                                 |
| <b>Urgently needed services - worldwide</b> | You pay a \$30 copayment for each visit in an urgent care center.                                                                                                      | You pay a \$50 copayment for each visit in an urgent care center.                                                                                          |
| <b>Urgently needed services</b>             | You are not required to pay the urgently needed services copayment if you are admitted to the hospital within 72 hours for the same condition.                         | You are not required to pay the urgently needed services copayment if you are admitted to the hospital within 24 hours for the same condition.             |
| <b>Urgently needed services</b>             | <p><b>Urgent care center</b><br/>You pay a You pay \$30 copayment for each visit.</p> <p><b>Retail walk-in clinic</b><br/>You pay a \$20 copayment for each visit.</p> | You pay a \$50 copayment for each visit to an urgent care center.                                                                                          |

|                                                  | 2025 (this plan year)                                                                                                                                                                                                                                                                                                                           | 2026 (next plan year)                                                                                                                                     |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Virtual behavioral visits</b>                 | You pay a \$0 copayment (in-network).                                                                                                                                                                                                                                                                                                           | You pay a \$40 copayment (in-network).                                                                                                                    |
| <b>Virtual behavioral visits</b>                 | You pay a \$0 copayment (out-of-network).                                                                                                                                                                                                                                                                                                       | You pay a \$40 copayment (out-of-network).                                                                                                                |
| <b>Virtual doctor visits</b>                     | <p>You pay a \$0 copayment for certain primary care provider, nurse practitioner, physician's assistant, or other non-physician health care professional services by designated providers.</p> <p>You pay a \$20 copayment using providers that have the ability and are qualified to offer virtual medical visits (in and out-of-network).</p> | You pay a \$0 copayment (in and out-of-network).                                                                                                          |
| <b>Vision care</b><br>Medicare-covered eye exams | <p>You pay a \$0 copayment for glaucoma screenings (in-network).</p> <p>You pay a \$30 copayment for Medicare-covered eye exams (in-network).</p>                                                                                                                                                                                               | <p>You pay a \$0 copayment for glaucoma screenings (in-network).</p> <p>You pay a \$40 copayment for Medicare-covered eye exams (in-network).</p>         |
| <b>Vision care</b><br>Medicare-covered eye exams | <p>You pay a \$0 copayment for glaucoma screenings (out-of-network).</p> <p>You pay a \$30 copayment for Medicare-covered eye exams (out-of-network).</p>                                                                                                                                                                                       | <p>You pay a \$0 copayment for glaucoma screenings (out-of-network).</p> <p>You pay a \$40 copayment for Medicare-covered eye exams (out-of-network).</p> |
| <b>Vision services</b><br>Routine eyewear        | Covered (in-network).                                                                                                                                                                                                                                                                                                                           | Routine eyewear is not covered (in-network).                                                                                                              |

|                                           | 2025 (this plan year)     | 2026 (next plan year)                            |
|-------------------------------------------|---------------------------|--------------------------------------------------|
| <b>Vision services</b><br>Routine eyewear | Covered (out-of-network). | Routine eyewear is not covered (out-of-network). |

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## Section 1.6 Changes to Part D Drug Coverage

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### Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. **You can get the complete Drug List** by calling Customer Service at 1-844-280-7754 (TTY users call 711) or visiting our website ([retiree.uhc.com/peracare](https://retiree.uhc.com/peracare)) to look up which drugs will be covered by your plan.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next plan year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your Evidence of Coverage and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. Call Customer Service at 1-844-280-7754 (TTY users call 711) for more information.

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## Section 1.7 Changes to Prescription Drug Benefits & Costs

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### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you.** We sent you a separate material, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs, which tells you about your drug costs. If you get Extra Help, you will receive a LIS Rider. If you don't get this material, call Customer Service at 1-844-280-7754 (TTY users call 711) and ask for the LIS Rider to be sent to you.

### Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your Part D drugs until you reach the yearly deductible.

• **Stage 2: Initial Coverage**

Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date out-of-pocket costs reach \$2,100.

• **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan’s full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don’t count toward out-of-pocket costs.

**Drug Costs in Stage 1: Yearly Deductible**

The table shows your cost per prescription during this stage.

|                          | 2025 (this plan year)                                                   | 2026 (next plan year) |
|--------------------------|-------------------------------------------------------------------------|-----------------------|
| <b>Yearly Deductible</b> | Because we have no deductible, this payment stage doesn’t apply to you. | \$300                 |

**Drug Costs in Stage 2: Initial Coverage**

Your cost-sharing in the Initial Coverage Stage may be changing from a copayment to coinsurance or a coinsurance to copayment. Go to the following table for the changes from 2025 to 2026.

The table shows your cost per prescription for a one-month (31-day) supply filled at a network pharmacy with standard cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for mail-order prescriptions, go to Chapter 6 of your **Evidence of Coverage**.

Once you’ve paid \$2,100 out of pocket for covered Part D drugs, you’ll move to the next stage (the Catastrophic Coverage Stage).

|                                    | 2025 (this plan year)                                                                                                       | 2026 (next plan year)                                                                                                       |
|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <b>Tier 1 - Preferred Generic</b>  | You pay \$15 per prescription.                                                                                              | You pay \$15 per prescription.                                                                                              |
| <b>Tier 2 - Preferred Brand</b>    | You pay \$45 per prescription.<br>You pay \$35 per month supply of each covered insulin product on this tier <sup>1</sup> . | You pay \$45 per prescription.<br>You pay \$35 per month supply of each covered insulin product on this tier <sup>1</sup> . |
| <b>Tier 3 - Non-Preferred Drug</b> | You pay \$60 per prescription.<br>You pay \$35 per month supply of each covered insulin product on this tier <sup>1</sup> . | You pay \$60 per prescription.<br>You pay \$35 per month supply of each covered insulin product on this tier <sup>1</sup> . |
| <b>Tier 4 - Specialty Tier</b>     | You pay \$75 per prescription.<br>You pay \$35 per month supply of each covered insulin product on this tier <sup>1</sup> . | You pay \$75 per prescription.<br>You pay \$35 per month supply of each covered insulin product on this tier <sup>1</sup> . |

<sup>1</sup> You will pay a maximum of \$35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible.

### Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage stage, you pay nothing for your covered Part D drugs. You may have cost sharing for additional drugs that are covered under our enhanced benefit.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6, in your **Evidence of Coverage**.

## Section 2 Administrative Changes

|                                           | 2025 (this plan year)                                                                                                                                                                                                                                                          | 2026 (next plan year)                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Medicare Prescription Payment Plan</b> | The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option. | If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.<br><br>To learn more about this payment option, call us at 1-844-280-7754 (TTY users call 711) or visit Medicare.gov.                                            |
| <b>Arkansas mail-order prescriptions</b>  | N/A                                                                                                                                                                                                                                                                            | Beginning January 1, 2026, Optum® Home Delivery Pharmacy and Optum Rx affiliates may no longer be available as a mail-order option in Arkansas. To find a new retail or mail-order pharmacy, sign in to your member site and select <b>Pharmacies &amp; Prescriptions</b> then <b>Find a pharmacy</b> or call Customer Service. |

## Section 3 How to Change Plans

**To stay in our plan, you don't need to do anything.** Unless you sign up for a different plan or change to Original Medicare, you'll automatically be enrolled in our UnitedHealthcare® Group Medicare Advantage (PPO).

**You should consult with your plan sponsor regarding the availability of other “employer-sponsored” coverage before you enroll in a plan not offered by your plan sponsor, or before ending your membership in our plan outside of your plan sponsor’s open enrollment period. It is important to understand your plan sponsor’s eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our plan.**

To learn more about Original Medicare and the different types of Medicare plans, visit [www.Medicare.gov](http://www.Medicare.gov), check the **Medicare & You 2026 handbook**, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE.

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### Section 3.1 Deadlines for Changing Plans

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**You can make plan changes during Open Enrollment from October 20 – November 20, 2025.**

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### Section 4 Get Help Paying for Prescription Drugs

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You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week;
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday - Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
  - Your State Medicaid Office.
- **Help from your state's pharmaceutical assistance program (SPAP).** State Pharmaceutical Assistance Program helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit [shiphelp.org](http://shiphelp.org), or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the ADAP in your state. For information on eligibility criteria, covered drugs, how to enroll in the program, or if you're currently enrolled, how to continue getting help, call the ADAP in your state. You can find your state's ADAP contact information in Chapter 2 of the **Evidence of Coverage**. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

- Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 1-844-280-7754 (TTY users call 711) or visit Medicare.gov.

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## Section 5 Questions?

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### Get Help from UnitedHealthcare® Group Medicare Advantage (PPO)

- **Call Customer Service at 1-844-280-7754. (TTY users call 711).**

We're available for phone calls 8 a.m.-8 p.m. local time, Monday-Friday. Calls to these numbers are free.

- **Read your 2026 Evidence of Coverage**

This **Annual Notice of Change** gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 **Evidence of Coverage** for UnitedHealthcare® Group Medicare Advantage (PPO). The **Evidence of Coverage** is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the **Evidence of Coverage** on our website at [retiree.uhc.com/peracare](https://retiree.uhc.com/peracare) or call Customer Service at 1-844-280-7754 (TTY users call 711) to ask us to mail you a copy.

- **Visit [retiree.uhc.com/peracare](https://retiree.uhc.com/peracare)**

Our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (formulary/drug list).

### Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state.

Call State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. You can find your SHIP number and address in Chapter 2, Section 3 of the **Evidence of Coverage**.

### Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with Medicare.gov**

You can chat live at [Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone).

- **Write to Medicare**

You can write to Medicare at PO Box 1270, Lawrence, KS 66044.

- **Visit Medicare.gov**

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read Medicare & You 2026**

The Medicare & You 2026 handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

## 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 numero 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.

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

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

## 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>**