Summary Plan Description

The Curators of the University of Missouri
Group Medicare Advantage PPO Plan

Effective: January 1, 2025
Group Numbers: 13796 (Base Plan) & 13797 (Enhanced Plan)

Discrimination is Against the Law

The Curators of the University of Missouri complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Curators of the University of Missouri does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Curators of the University of Missouri:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Carol Wilson, Director, Health & Benefits.

If you believe that The Curators of the University of Missouri has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Carol Wilson, Director, Health & Benefits
1105 Carrie Francke Dr, Suite 108, Columbia, MO 65211
Phone: 573-882-2406
Fax: 573-882-9155
wilsoncaro@umsystem.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Carol Wilson, Director, Health & Benefits, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

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

- **ATENCIÓN**: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-634-1237.

- **注意**：如果您使用繁體中文 ， 您可以免費獲得語言援助服務 。請致電 1-844-634-1237。

- **CHÚ Ý**: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-634-1237.

- **OBAVJEŠTENJE**: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-634-1237.

- **ACHTUNG**: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-634-1237.

- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-634-1237

- **ВНИМАНИЕ**: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-634-1237.

- **주의**: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-634-1237. 번으로 전화해 주십시오.

- **ATTENTION**: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-634-1237.

- **PAUNAWA**: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-634-1237

- Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-634-1237.

- توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-634-1237 تماس بگیرید.

- **XIYYEEFFANNAA**: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-634-1237.

- ATENÇÃO: Se fal a português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-634-1237.

- ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-844-634-1237.

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ATTACHMENT 1 – Plan Guide 2025, UnitedHealthcare Group MedicareAdvantage Plan (PPO) – Group No. 13796 and 13797

SECTION 1 - WELCOME

Quick Reference Box
Customer services and claims questions:

- Call: 1-866-899-5903
- Write: UnitedHealthcare - Claims, P.O. Box 30770, Salt Lake City, UT 84130-0770
- Online: **www.UHCRetiree.com/umsystem**

The Curators of the University of Missouri (the University) sponsors this Plan (which includes both medical and prescription drug benefits described in Section 3, *How the Plan Works*) for the benefit of its eligible Retired Employees (Retirees) and LTD Recipients whoare eligible for Medicare and their Dependents.

This Summary Plan Description (SPD) includes all contracts between the University and anyinsurer, service provider, or third-party administrator attached to this document as Attachments and such contracts are hereby incorporated herein by reference. The SPD describes the medical and prescription drug Benefits available to eligible Retired Employees (Retirees), LTD Recipients and eligible Dependents under the Plan as of January 1, 2024.

This SPD serves as both the Plan document and the SPD. It includes summaries of:

- who is eligible;
- services that are covered;
- services that are not covered;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan. It is important that you carefully review this SPD to understandthe Benefits which are available, as well as your responsibilities to ensure that you receive all the Benefits to which you are eligible. If a service or procedure is not specifically referenced in the SPD, coverage will be in accordance with UnitedHealthcare standard policies or determined at the discretion of the Employer. The terms of this Plan may not be amended by oral statements made by anyone. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

IMPORTANT

The University intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, coinsurance, exclusions, limitations, definitions, eligibility and the like. Such action may affect Retirees/LTD Recipients and may be in the form of Benefits or contribution amounts. If the Plan is terminated, amended or Benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment or elimination. The Plan shall be construed and administered to comply in all respects with applicable federal law. In addition to this Plan document, we will continue to use other methods of communication such as memos, meetings, newsletter articles or electronic media to help you stay informed.

If there should be an inconsistency between the contents of this SPD (including Attachments to this SPD) and any other written document, your rights shall be determined under this SPD.

How To Use This SPD

- Read the entire SPD thoroughly to learn how the Plan works and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- Copies of this SPD and any future amendments are located on The UM System Office of Human Resources website (http://umurl.us/TR) or you can request printed copies by contacting the HR Service Center at 573-882-2146.
- Capitalized words in the SPD have special meanings and are defined in Section 5, *Glossary*.
- The Curators of the University of Missouri is also referred to as "the University".
- The term "written application" includes electronic forms.
- If there is a conflict between this SPD (including Attachments to this SPD) and any benefit summaries (other than Summaries of Material Modifications), any summary of benefit coverage (SBC), or other written information provided to you, this SPD will control.
- When there is a reference to "the Plan" in this SPD it is referring to the Group Medicare Advantage PPO Plan.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if:

- you are eligible for Medicare due to age or disability; and
- you are enrolled in Medicare Part A and Part B; and
- you live in UnitedHealthcare's geographic service area (described in Section 2.3 of Exhibit A); and
- you are a United States citizen or are lawfully present in the United States; and either
- you are a Long-Term Disability Recipient (LTD Recipient); or
- you are a Retired Employee (Retiree) and the following conditions are met:
    - If you are Medicare eligible on your retirement date, you were covered under a University Active Employee Medical Plan immediately prior to your retirement date; or
      Immediately preceding when you first became Medicare eligible, you were enrolled in either the Curators of the University of Missouri Retiree and Disability Health PPO Plan or Retiree Healthy Savings Plan; and
    - If you retired on or before December 31, 2017, you were either:
        - age 55 or older with at least 10 years of service, or
        - age 60 or older with at least 5 years of service; or

      If you retire on or after January 1, 2018, you must have been employed in a UM System benefit eligible position and accumulated at least five years of service, as measured by the University of Missouri Retirement, Disability and Death Benefit Plan on December 31, 2017, and on your retirement date you must:
        - be at least 60 years old; and
        - have at least 20 years of service with the UM System.

If you meet the eligibility requirements above, but your eligibility for Medicare is due to End Stage Renal Disease (ESRD), you will become eligible for this Plan after a 30-month coordination period. The coordination period begins on the date you first become eligible for Medicare because of ESRD (regardless of whether or not you actually enroll in Medicare). If you are participating in a University Active Employee Medical Plan or a

University Retiree/LTD Recipient Medical Plan at the time you become eligible for Medicare due to ESRD, you will remain covered under that plan during your coordination period (provided all other eligibility requirements of that plan are satisfied).

If you are a Retired Employee, are reemployed by the University after your retirement, and subsequently retire again, special rules apply:

- If, upon your initial retirement from the University, you were eligible to enroll in the Plan based on your satisfaction of the eligibility requirements above, you will be eligible to reenroll in the Plan upon your retirement following reemployment (even if you did not initially enroll after your initial retirement), provided you still meet all requirements above. For purposes of determining whether you still meet the requirements above upon your retirement following reemployment, your initial date of retirement will determine which eligibility requirements apply. For example, if you initially retired on August 1, 2017, and retired following reemployment on August 1, 2019, you must meet the age and service requirements above for individuals who retired on or before December 31, 2017, not the age and service requirements for individuals who retire on or after January 1, 2018.
- If, upon your initial retirement from the University, you were <u>not</u> eligible to enroll in the Plan, your eligibility to enroll in the Plan upon your retirement following reemployment depends on your reemployment date:
    - If you are reemployed prior to January 1, 2020, and upon your retirement following reemployment you now satisfy the eligibility provisions above, you may enroll in this Plan upon your retirement following reemployment. You must meet the eligibility requirements above applicable to the date of your retirement following reemployment.
    - If you are reemployed on or after January 1, 2020, you may not enroll in this Plan upon your retirement following reemployment, even if you now satisfy the eligibility provisions above.

If you experience a termination from employment, but were not eligible for retirement under the University's Retirement, Disability and Death Benefit Plan, are reemployed by the University, and subsequently separate from employment again, special rules apply:

- If you are reemployed prior to January 1, 2020, and upon your separation following reemployment you satisfy the eligibility provisions above, you may enroll in this Plan upon your separation following reemployment. You must meet the eligibility requirements above applicable to the date of your separation following reemployment.
- If you are reemployed on or after January 1, 2020, you may not enroll in this Plan upon your separation following reemployment if you did not meet the eligibility requirements above on the date of your initial termination from employment, even if you satisfy the eligibility provisions above at the time of your separation following reemployment.

If you are eligible to reenroll (or enroll for the first time) upon retirement or separation after reemployment, you must enroll in this Plan consistent with the requirements in *How to Enroll*, Section 2, *Introduction*.

Dependents

Your eligible Dependent(s) may also participate in the Plan if the Dependent:

- is eligible for Medicare due to age or disability;
- is enrolled in Medicare Part A and Part B;
- lives in UnitedHealthcare's geographic service area (described in Section 2.3 of Exhibit A); and
- is a United States citizen or is lawfully present in the United States.

If your Dependent meets the eligibility requirements above, but their eligibility for Medicare is due to End Stage Renal Disease (ESRD), the Dependent will become eligible for this Plan after a 30-month coordination period. The coordination period begins on the date the Dependent first becomes eligible for Medicare because of ESRD (regardless of whether or not the Dependent actually enrolls in Medicare). If your Dependent is participating in a University Active Employee Medical Plan or a University Retiree/LTD Recipient Medical Plan at the time they become eligible for Medicare due to ESRD, they will remain covered under that plan during their coordination period (provided all other eligibility requirements of that plan are satisfied).

Your Dependents **may not** enroll in the Plan unless you are also enrolled in this Plan or another University Retiree/LTD Recipient Medical Plan. Under no circumstances may any person be enrolled in any University-sponsored health plan under more than one participant.

- If your Dependent is not Medicare eligible, he or she will not be eligible to participate in this Plan, but may be eligible to participate in another University Retiree/LTD Recipient Medical Plan.
- If You and your Spouse or Sponsored Adult Dependent are eligible for coverage under any University-sponsored health plan and you have Dependent Children, only one parent may enroll your Child as a Dependent.
- If You are eligible for Coverage as both a Spouse or Sponsored Adult Dependent and a Child, only one participant may enroll you in a University-sponsored health plan as a Dependent.

Notwithstanding the foregoing, if you are a LTD Recipient, your Medicare eligible Dependent may participate in this Plan even if your Dependent was not continuously covered by a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan or was not covered at the time you became a LTD Recipient, but the effective date of such coverage will be different. See *When Coverage Begins*, below, for more information.

If you are a Retiree, the Plan will not cover a person who:

- becomes your Dependent after the date of your retirement; or
- was your Dependent prior to retirement but who you did not enroll in this Plan or

another University Retiree/LTD Recipient Medical Plan at the time of your retirement; or

- was covered but later dropped from coverage by you, the Retiree

unless:

- the Dependent is a Child and experiences a qualifying family/employment status change; or
- your Spouse/Sponsored Adult Dependent is also a University benefit eligible employee who separates from the University and/or loses eligibility for retiree medical insurance, but only if they were enrolled in a University Active Employee Medical Plan as an eligible employee; or
- you are reemployed by the University after your initial retirement and you enroll an eligible Dependent during your period of reemployment (and all other eligibility requirements are satisfied with respect to that Dependent and you at the time of your retirement following reemployment).

If you and your Spouse or Sponsored Adult Dependent are eligible for coverage under a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan and you have Dependent Children, only one of you may claim the Children as covered Dependents.

IMPORTANT: Documentation is required to enroll a Dependent under this Plan. When you enroll a Dependent under this Plan, you must provide proof of that Dependent's relationship to you and satisfaction of the Plan's Dependent eligibility requirements. If you are enrolling a Dependent outside of the Annual Enrollment period due to a loss of coverage, you must also provide proof of coverage loss (i.e., certificate of creditable coverage or letter from former plan). A Dependent may participate in the Plan only if documentation proving the Dependent's relationship to the employee and loss of coverage (when applicable) is submitted to the University.

Acceptable documentation is located on The UM System Office of Human Resources website under forms & guides: **http://umurl.us/proof**.

- In the case of Dependents of LTD Recipients added during Annual Enrollment, documentation must be submitted within 31 days of the close of Annual Enrollment or coverage will not be effective on January 1 of the following Plan Year.
- For enrollment occurring outside of Annual Enrollment period (e.g., because of a special enrollment right or a family/employment status change), all required documentation must be submitted to the University within 31 days of the date you enroll the Dependent in the Plan. Failure to timely provide the required documentation will result in retroactive termination of the Dependent's coverage to the date coverage began.

When you enroll a Dependent in the Plan, you represent the following to be true:

- The individual is eligible under the terms of the Plan; and

- You will provide documentation evidencing eligibility (including proof of loss of coverage, if applicable) within 31 days of the date the individual is enrolled in the Plan (or within 31 days of the close of Annual Enrollment in the case of Dependents added during Annual Enrollment).

Further, you understand that:

- The Plan is relying on your representation of eligibility in accepting the enrollment of your Dependent(s);
- Your failure to provide the required documentation may be evidence of fraud and material misrepresentation; and

Newborns: Documentation of a LTD Recipient's newborn eligibility must be provided to the University within 31 days of enrolling the newborn in the Plan (if the newborn is Medicare eligible). Coverage for the newborn Dependent will exist as requested for 31 days and will terminate on the 32nd day if the required documentation is not submitted to the University (i.e., coverage will not be retroactively rescinded, but will terminate prospectively beginning on the 32nd day). If the newborn is not Medicare eligible, the newborn is not eligible for coverage under this Plan, but may be eligible for coverage under a University Active Employee Plan or University Retiree/LTD Recipient Plan.

If you are eligible for coverage under this Plan as both a Retiree and a Dependent Spouse of a Retiree with the same type of subsidized cost of coverage (percentage subsidy vs. flat subsidy), you have an important decision to make. If you elect to enroll as a Dependent Spouse of a Retiree, you will forfeit your right to enroll in this Plan at a future date as a Retiree, unless you divorce your Retiree Spouse or unless you are reemployed by the University and meet the eligibility requirements of this Plan upon your retirement or separation following reemployment. If divorce occurs, you must contact the UM Office of Human Resources within 31 days of the effective date of the divorce to obtaininformation about continued eligibility under this Plan as a Retiree.

If you are eligible for coverage under this Plan as both a Participant and Dependent, you may enroll as either a Participant or Dependent, but not both.

For more information, see *Other Events Ending Your Coverage* in Section 4, *When Coverage Ends*.

Cost of Coverage

The Premium associated with the cost of medical coverage is shared between you and the University. The amount the University contributes toward the cost of your coverage is called a subsidy. Your subsidy depends on your retirement date and other factors, as described below, and may be modified in the future. If you retire or experience a termination of employment (other than retirement) from the University, are subsequently reemployed by the University or "freeze" your retirement coverage to instead receive coverage under this Plan as a LTD Recipient, and you retire (either for the first time or again) and are eligible to enroll in this Plan (see *Eligibility*, Section 2, *Introduction*), your subsidy category will be determined by your original retirement date (not a subsequent retirement date in the event of a second retirement following reemployment). How your subsidy is calculated upon your retirement following reemployment or coverage as a LTD Recipient depends on when you were reemployed or switched to coverage as a LTD Recipient:

- If, prior to January 1, 2020, you are reemployed as an active employee or choose to participate under this Plan as a LTD Recipient instead of a Retiree after previously retiring or separating, your subsidy (if a subsidy applies based on your retirement date, below) will be calculated using your age and years of UM service credit at your retirement following reemployment or following the end of your coverage under thisPlan as a LTD Recipient. In other words, upon your subsequent retirement following reemployment or the end of your coverage as a LTD Recipient, your subsidy will be determined using any additional UM credit you accrue while reemployed or as a LTD Recipient (in accordance with the University's Retirement, Disability and Death Benefit Plan) and your age at the time of your subsequent retirement. Nothing in this paragraph should be construed to supersede the requirements set forth below with respect to Employees who retire on or after January 1, 2018. That is, additional service and age does not affect your Access Category as determined on January 1, 2018 (but such additional service and age may affect your eligibility for coverage and/or the subsidy under such Access Category). See *RETIRED ON OR AFTER JANUARY 1, 2018*, below, for more information about Access Categories.
- If, on or after January 1, 2020, you are reemployed as an active employee or choose to participate under this Plan as a LTD Recipient instead of a Retiree after previously retiring, your subsidy (if a subsidy applies based on your retirement date, below) will be calculated using your age and years of UM service credit on the date of your:

    - termination from employment preceding reemployment, if your reemployment followed a termination from employment other than for retirement; or
    - initial retirement, if your reemployment followed a retirement.

    In other words, upon your subsequent retirement following reemployment, your subsidy will not be adjusted to account for your increased age or any additional UM service credit you may have accrued while reemployed. Likewise, if you retire while you are awaiting a disability determination under the University's Long-Term Disability Plan, are subsequently determined to be totally and permanently disabled under such plan and "freeze" Retiree coverage under this Plan to participate instead as a LTD Recipient, for purposes of this Plan and the subsidies offered hereunder, only your age and UM service credit at the time of your initial retirement will be considered.

Retirees

RETIRED PRIOR TO SEPTEMBER 1, 1990 OR RETIRED UNDER THE CSRS OR FERS PRIOR TO JANUARY 1, 2018.

If you retired prior to September 1, 1990, under the University of Missouri Retirement, Disability and Death Benefit Plan or the Missouri State Employees Retirement System or you retired prior to January 1, 2018 under the Civil Service Retirement System (CERS) or Federal Employees Retirement System (FERS), the cost of coverage under this Plan will be divided by the University and you and/or your Dependents in the following manner:

	Percentage of Cost the University Will Pay (Subsidy)	Percentage of Cost You or Your Dependents Will Pay
Retiree	66.67%	33.33%
Spouse/Sponsored Adult Dependent/Dependent	66.67%	33.33%
Surviving Spouse/Surviving Sponsored Adult Dependent/Surviving Dependent	33.33%	66.67%

- The University may, in its sole discretion, subsidize in part or in full any non-Premium related Plan fees for Covered Persons enrolled in this Plan.

RETIRED ON OR AFTER SEPTEMBER 1, 1990 AND PRIOR TO JANUARY 1, 2018

If you retired on or after September 1, 1990 and prior to January 1, 2018, under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Employees Retirement System, the division of the cost of coverage between you and the University is calculated individually based on age and length of service at retirement. The cost of coverage under this Plan will be divided by the University and you and/or your Dependents in the following manner:

Age at Retirement Plus Years of UM Service Credit	Percent of UM Maximum Premium Subsidy*
Less than 75	50%
Equal to or greater than 75 but less than 90	75%
Equal to or greater than 90	100%

*The UM maximum premium subsidy is a percentage of the total cost of the Plan, as shown below:
Group Medicare Advantage PPO Plan Maximum Premium Subsidy = 66.67 %

Example: If your age plus years of UM service credit is equal to or greater than 90, your subsidy under this Group Medicare Advantage PPO Plan is 100% of the maximum premium subsidy for this Plan (66.67%). If your age plus years of UM service credit is equal to or greater than 75 but less than 90, your subsidy under this Plan is 75% of the maximum premium subsidy (66.67%). If your age plus years of UM service credit is less than 75, your subsidy under this plan is 50% of the maximum premium subsidy (66.67%).

- This Plan offers a base option and an enhanced "buy up" option. If you choose the enhanced option, you must pay 100% of the difference between the base option and

the enhanced option (plus your applicable percentage of the cost for the base option). The University may, in its sole discretion, subsidize in part or in full any non-Premium related Plan fees for Covered Persons enrolled in this Plan.

- For a Spouse, Sponsored Adult Dependent, Surviving Spouse, Surviving Sponsored Adult Dependent, or surviving Dependent, the University's subsidy will be one-half of the Retiree's "Percent of UM Maximum Premium Subsidy" determined from the table above.

RETIRED ON OR AFTER JANUARY 1, 2018

If you retire on or after January 1, 2018, under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Employees Retirement System, the University's subsidy is either a fixed annual amount or a percentage subsidy based on your Access Category earned on December 31, 2017.

- If, on December 31, 2017, you were 60 years or older and had earned 20 or more years of service (Access Category A), you will receive a subsidy equal to Retirees who retired on or after September 1, 1990, as stated above. For Spouses, Surviving Spouses and other Covered Dependents of Retirees, the University's subsidy will be one-half (1/2) of the Percent of UM Maximum Premium Subsidy determined from the above table.
- If, on December 31, 2017, your age plus years of service was equal to or greater than 80, but you were not 60 years old or had not earned 20 years of service (Access Category B), and on your retirement date you are 60 years or older and have at least 20 years of service, you will receive a subsidy equal to Retirees who retired on or after September 1, 1990, as stated above. For Spouses, Surviving Spouses and other Covered Dependents of Retirees, the University's subsidy will be one-half (1/2) of the Percent of UM Maximum Premium Subsidy determined from the above table.
- If, on December 31, 2017, your age plus years of service was less than 80, but you had earned 5 or more years of service credit (Access Category C), and on your retirement date you are 60 years or older and have at least 20 years of service, you will receive a fixed subsidy equal to $100 multiplied by your years of service, not to exceed $2,500 annually to purchase UM medical and/or dental coverage. Surviving Spouses and Surviving Sponsored Adult Dependents of Retirees will receive $0 subsidy.
- If, on December 31, 2017, you had earned less than 5 years of service credit or you were initially hired on or after December 31, 2017 (Access Category D) or if you are Access Category B or C as defined above and on your retirement date you are not 60 years or older and do not have at least 20 years of service, you are not eligible to participate in this Plan, and you are not eligible for any subsidy.

The University may, in its sole discretion, subsidize in part or in full any non-Premium related Plan fees for Covered Persons enrolled in this Plan.

You must elect to continue enrollment in this Plan to be eligible for a subsidy described above. Under no circumstances will you receive any subsidy amount that exceeds the

premium for this Plan (plus the premium for University sponsored dental coverage, if such coverage is elected).

LTD Recipients

You and the University share in the cost of coverage under this Plan. Your Contribution amount depends on the family members you choose to enroll. Contributions are payable monthly to the University and are paid during the month to which the Contribution applies. You shall not maintain participation beyond the date on which the next Contribution becomes payable. Monthly Contributions for participation shall cease at the end of the month in which the LTD Recipient ceases to be eligible under this Plan.

Dependents of Retirees or LTD Recipients

The level of Premium subsidy is limited to ten Dependent Children. Retirees/LTD Recipients will be required to pay the full Premium cost for each Child that is enrolled beyond the maximum of ten.

Retirees/LTD Recipients who have coverage for over ten Children as of December 31, 2001, will continue to receive Premium support for all Children covered as of that date. Coverage for any new Children over the maximum of ten who are enrolled on or after January 1, 2002, will require payment of the entire Premium by the Retiree/LTD Recipient.

Reimbursement Right

In the event a Retiree/LTD Recipient enrolls an ineligible individual (including themselves or any Dependents) under the Plan, or a covered Retiree/LTD Recipient or Dependent becomes ineligible for coverage under the Plan and the Plan does not receive notification of an enrollment change within 31 days of a qualifying event or qualifying family/employment status change or Medicare Part A or Part B ineligibility, any claims paid on behalf of such ineligible individual, while such individual was ineligible, will be reversed. If the Retiree/LTD Participant commits an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact with respect to coverage under this Plan, including, but not limited to, knowinglyproviding incorrect information relating to another person's eligibility or dependent status orfailing to timely provide required documentation evidencing proof of relationship or loss of coverage (if applicable) (see *Eligibility* in this Section 2, above for more information), coverageunder this Plan will terminate retroactively (see *Other Events Ending Your Coverage* in Section 4,*When Coverage Ends*) and claims paid on behalf of that individual must be reimbursed to the Plan.

How to Enroll

Retirees

To enroll, you must complete the Plan's enrollment form within 31 days of:

- your retirement date (or within 31 days of your retirement date following reemployment, provided you are eligible to enroll) if you are enrolling in this Plan immediately following active employment; or
- the date you become Medicare eligible if you are already retired and enrolled in coverage under a University Retiree/LTD Recipient Medical Plan for non-Medicare eligible Retirees.

If two Employees and/or Retirees are covered under the Plan and the Employee/Retiree who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee/Retiree with no waiting period as long as coverage has been continuous. This request must be made within 31 days of the status change.

If you suspended coverage under this or another University Retiree/LTD Recipient Medical Plan (or a predecessor to such plans) **prior to January 1, 2017**, in order to enroll in a non-University medical insurance plan:

- You may opt to resume participation in a University Retiree/LTD Recipient Medical Plan by selecting and submitting your plan choice(s) during the University's Annual Enrollment period for Retirees. Your selected coverage will be effective January 1 of the following calendar year. In order to re-enroll, you must provide satisfactory proof that the non-University medical insurance plan coverage was in effect during the entire period of time your coverage under a University Retiree/LTD Recipient Medical Plan was suspended, up to the reinstatement date (January 1 of the following calendar year), with no breaks in coverage. Satisfactory proof of coverage includes a letter of creditable coverage or a letter verifying continuous coverage from the medical plan.

If you suspended coverage under this Plan or another University Retiree/LTD Recipient Medical Plan **on or before January 1, 2018**, in order to enroll as a Dependent on your Spouse or Sponsored Adult Dependent's University Active Employee Medical Plan:

- You may resume participation in a University Retiree/LTD Recipient Medical Plan under the following conditions:
    - You were eligible to participate in the University Retiree/LTD Recipient Medical Plan prior to when you suspended benefits;
    - Your Spouse or Sponsored Adult Dependent retires, terminates employment or experiences another qualifying employment/family status change;
    - You maintained coverage for the entire period of the suspension and were enrolled as a Dependent of an active employee covered by a University Active Employee Medical Plan; and
    - You complete the required retiree insurance enrollment form within 31 days after your Spouse or Sponsored Adult Dependent loses coverage under a University Active Employee Medical Plan.

If you become Medicare eligible due to age or disability, you are no longer eligible tobe enrolled as a dependent through your Spouse's or Sponsored Adult Dependent's University Medical Plan. You must notify the UM System Office of Human Resources at least 60 days prior to the effective date of Medicare eligibility.

If you do not immediately reinstate retiree insurance coverage upon loss of coverage under a University Active Employee Medical Plan through your Spouse or SponsoredAdult Dependent, you forfeit your right to re-enroll in a University Retiree/LTD Recipient Medical Plan at a later date.

If, after retirement, you were eligible for a University Retiree/LTD Recipient Medical Plan and you become reemployed by the University or a University subsidiary entity and you become eligible for coverage as an "Employee" under (and as defined by) a University Active Employee Medical Plan, your coverage under such active plan will commence as follows: If your reemployment date is the first of the month, your employee coverage will commence on that date. If your reemployment date is effective any other day of the month, your employee coverage will commence on the first of the month following your rehire date. Your retiree medical coverage under this Plan will "freeze". Upon your termination from regular employment and loss of coverage under a University Active Employee Medical Plan (or upon loss of coverage under a University Active Employee Medical Plan even while you are still employed, because you no longer meet the definition of "Employee"), if you are eligible to enroll in this Plan, ***you must immediately enroll in (if you were not previously enrolled but were eligible to do so at your initial retirement date) or reinstate retiree medical insurance coverage*** or you will forfeit your right to participate in a University Retiree/LTD Recipient Medical Plan at alater date.

Employee means "Employee" as defined in each of the University Active Employee Medical Plans. See *Eligibility* in Section 2, *Introduction*, of those summary plan descriptions.

LTD Recipients

To enroll, you must complete the Plan's enrollment form within 31 days of:

- receipt of notice that you are Disabled under the University's Long-Term Disability Plan and are eligible to receive benefits under the University's Long-Term Disability Plan if you are enrolling in this Plan immediately following active employment (and are Medicare eligible); or
- the date you become Medicare eligible if you are already enrolled in coverage under a University Retiree/LTD Recipient Medical Plan for non-Medicare eligible LTD Recipients.

Surviving Spouses/Surviving Sponsored Adult Dependents

Enrollment for continued medical coverage must be made within 31 days after the Retiree's/LTD Recipient's death. For more information see *Continuation of Medical Coverage for Dependents after the Death of a Retiree/LTD Recipient* in Section 4, *When Coverage Ends*.

When Coverage Begins

Retirees

Coverage will begin as outlined below, provided that you have completed and returned the Plan enrollment form prior to your coverage effective date.*

- If you are Medicare eligible on the day of your retirement, and you retire on the first of the month, coverage under this Plan begins on that day (provided all necessary enrollment forms have been submitted to the University).
- If you are Medicare eligible on the day of your retirement, and you retire after the first of the month, coverage will begin the first of the month following your retirement date.
- If you are not Medicare eligible on the day of your retirement, but you become Medicare eligible after retirement and such eligibility is effective on the first day of the month, coverage under this Plan begins on that day (provided all necessary enrollment forms have been submitted to the University).

*You have up to 31 days after the later of your retirement date or Medicare effective date to complete the Plan enrollment form. However, if the enrollment form is completed after the coverage effective date, it may affect the date coverage would have otherwise begun under this Plan.

Dependents of Retirees

Coverage will begin as outlined below, provided that you have completed and returned the Plan enrollment form prior to your Dependent's(s') coverage effective date.*

- If you are not Medicare eligible when you retire, but your Dependent is Medicare eligible on your retirement, Dependent coverage is effective under this Plan on the date your coverage is effective under a University Retiree/LTD Recipient Medical Plan for non-Medicare eligible Retirees.
- If neither you nor your Dependent is Medicare eligible when you retire, but your Dependent becomes Medicare eligible before you, Dependent coverage under this Plan is effective on the first day of the month in which the Dependent becomes Medicare eligible.
- If your Dependent becomes Medicare eligible after you, Dependent coverage under this Plan is effective on the first day of the month in which the Dependent becomes Medicare eligible.
- If both you and your Dependent are Medicare eligible when you retire, Dependent coverage is effective on the date your coverage becomes effective.

*You have up to 31 days after the later of your retirement date or Medicare effective date to complete the Plan enrollment form. However, if the enrollment form is completed after the coverage effective date, it may affect the date coverage would have otherwise begun under this Plan.

As described in "*Eligibility*," above, Retirees are not eligible to add Dependents to this Plan after the date of retirement, unless the Dependent is a Child that experiences a qualifying

family/employment status change or the Retiree's Spouse/Sponsored Adult Dependent is also a University benefit eligible employee who separates from the University and/or loses eligibility for retiree medical insurance, but only if they were enrolled in a University Active Employee Medical Plan as an eligible employee.

In the event of a qualifying family/employment status change, the Dependent Child will become a Participant provided the Retiree makes written application (including proof of relationship) for such Child. Coverage will become effective for the Child as follows (provided the Child is Medicare eligible)*:

- in the case of birth or adoption or placement for adoption, on the first of the month of the date of the event, as applicable, and
- in the case of any other event, if the event occurs on the first day of the month, coverage will become effective on that date; otherwise, coverage will become effective on the first of the month following the date of theevent.

*You have up to 31 days after the later of your retirement date or Medicare effective date to complete the Plan enrollment form. However, if the enrollment form is completed after the eligibility date, it may affect the date coverage would have otherwise begun under this Plan.

In the event that your Spouse or Sponsored Adult Dependent is also a University benefit eligible employee who separates from the University and/or loses eligibility for retiree medical insurance, you may add your Medicare eligible Spouse or Sponsored Adult Dependent as a Dependent to coverage under a University Retiree/LTD Recipient Medical Plan (and any eligible Dependent Children) if they were enrolled in a University Active Employee Medical Plan under your Spouse's coverage as an eligible employee. You must make written application (including proof of relationship) for such Spouse or Sponsored Adult Dependent and eligible Dependent Children within 31 days after the change in status. Coverage will become effective for Participants on the first of the month following the date of the event (provided the necessary forms are submitted to the University).

For more information on what constitutes a qualifying family/employment status change, please refer to "*Changing your Coverage*," below.

Notwithstanding the foregoing, if you are reemployed by the University after your initial retirement and you enroll an eligible Dependent during your period of reemployment, that Dependent may continue coverage under this Plan upon your retirement following reemployment, provided all other eligibility requirements are satisfied with respect to that Dependent.

LTD Recipients

Coverage will begin as outlined below, provided that you have completed and returned the Plan enrollment form prior to your coverage effective date.*

- If you are Medicare eligible on your Disability Benefit Commencement Date, and the commencement date is the first of the month, coverage under this Plan begins on that day.
- If you are Medicare eligible on the Disability Benefit Commencement Date, and the

commencement date is after the first of the month, coverage will begin the first of the month following the Disability Benefit Commencement Date.

- If you are not Medicare eligible on the Disability Benefit Commencement Date, but you become Medicare eligible after the commencement date, coverage under this Plan begins on the effective date of your Medicare eligibility.

*You have up to 31 days after the later of your retirement date or Medicare effective date to complete the Plan enrollment form. However, if the enrollment form is completed after the coverage effective date, it may affect the date coverage would have otherwise begun under this Plan.

If you were not covered by a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan immediately preceding your Medicare eligibility, you may still participate in this Plan. However, your coverage will not be effective until January 1 following the year in which you enroll during Annual Enrollment or, if sooner, the first of the month following a special enrollment right or a qualifying family/employment status change.

Dependents of LTD Recipients

Coverage will begin as outlined below provided that you have completed and returned the Plan enrollment form prior to your Dependent's(s') coverage effective date.*

- If you are not Medicare eligible on the Disability Benefit Commencement Date, but your Dependent is Medicare eligible, Dependent coverage is effective under this Plan on the date your coverage is effective under a University Retiree/LTD Recipient Medical Plan for non-Medicare eligible LTD Recipients, provided your Dependent was previously covered by a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan immediately prior to the coverage effective date.
- If neither you nor your Dependent is Medicare eligible on the Disability Benefit Commencement Date, but your Dependent becomes Medicare eligible before you, Dependent coverage under this Plan is effective on the first day of the month in which the Dependent becomes Medicare eligible, provided your Dependent was previously covered by a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan immediately prior to becoming Medicare eligible.
- If your Dependent becomes Medicare eligible after you, Dependent coverage under this Plan is effective on the first day of the month in which the Dependent becomes Medicare eligible, provided your Dependent was previously covered by a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan immediately prior to becoming Medicare eligible.
- If both you and your Dependent are Medicare eligible on the Disability Benefit Commencement Date, Dependent coverage is effective on the date your coverage becomes effective, provided your Dependent was previously covered by a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan immediately prior to the coverage effective date.

*You have up to 31 days after the later of your retirement date or your Disability Benefit

Commencement Date to complete the Plan enrollment form. However, if the enrollment form is completed after the coverage effective date, it may affect the date coverage would have otherwise begun under this Plan.

If a LTD Recipient requests coverage in writing (including proof of relationship) for a Medicare eligible Dependent, other than a Spouse, more than 31 days after such Dependent first becomes eligible for coverage, the following rules will apply:

- If the LTD Recipient request (and proof of relationship) is received within 180 days after the Dependent first becomes eligible, and such Dependent is a newborn or an adopted Child for whom specific additional LTD Recipient Contribution is required (i.e., coverage for other Children does not already exist), coverage for such Dependent will be provided for 31 days, beginning in the month of the birth or adoption (as applicable), will cease as of the 32nd day, and then resume on the date the LTD Recipient's written request is received. If the LTD Recipient request for coverage (including proof of relationship) is not received within the 180 day period specified above, the LTD Recipient may request coverage during the next subsequent Annual Enrollment period, and coverage will be provided for 31 days, beginning in the month of birth or adoption (as applicable), will cease as of the 32nd day, and will resume as of the January 1 following receipt of the LTD Recipient's request during the Annual Enrollment period.
- If the LTD Recipient request (including proof of relationship) is received within 180 days after the Dependent first becomes eligible, and such Dependent is a Child other than a newborn or adopted Child for whom specific additional LTD Recipient Contribution is required (i.e., coverage for other Children does not already exist), coverage for such Child will become effective the first of the month following the date on which the benefit enrollment form (and proof of relationship) is submitted to the UM System Office of Human Resources. If the LTD Recipient request for coverage (including proof of relationship) is not received within the 180 day period specified above, the LTD Recipient may request coverage during the next subsequent Annual Enrollment period designated by the University, and coverage will become effective on the following January 1.
- If the LTD Recipient request (including proof of relationship) is received within 180 days after the Dependent first becomes eligible, and the Dependent for whom coverage is requested is a Child for whom specific additional LTD Recipient Contribution is not required (i.e., coverage already exists for other eligible Children), coverage will be effective as follows:
    - In the case of birth or adoption or placement for adoption, on the first of the month of the date of the event, as applicable, and
    - In the case of any other event, on the date coverage is requested.

If a LTD Recipient does not timely enroll or waive coverage with respect to a Dependent in the scenarios above, or if the LTD Recipient's Dependent was not previously covered by a University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan immediately prior to becoming Medicare eligible, the Medicare eligible Dependent may still participate in this Plan beginning on the earliest of:*

- January 1 following the year in which you timely enroll your Dependent during

Annual Enrollment;

- The first day of the month following the month in which the Dependent is eligible for a special enrollment right or experiences a qualifying family/employment status change; or
- The date the person becomes your Dependent.

* The Plan enrollment form must be complete before the coverage effective date listed above. If the enrollment form is completed after the coverage effective date, it may affect the date coverage would have otherwise begun under this Plan.

Other Special Rules for LTD Recipients

- If your Spouse or Sponsored Adult Dependent is an employee of the University and enrolled in a University Active Employee Medical Plan and ceases to participate in such coverage by reason of a change in employment status, your Spouse (or Sponsored Adult Dependent) will be covered under this Plan as a Dependent in accordance with the timing rules immediately above in *Dependents of LTD Recipients* or with the provisions covering special enrollment rights or qualifying family/employment status changes, provided you make timely written application for your Spouse or Sponsored Adult Dependent.
- Except in accordance with the provisions covering special enrollment rights or a qualifying family/employment status change, a LTD Recipient may add Dependents under this Plan only during the Plan's Annual Enrollment period.
- An LTD Recipient may remove himself/herself or a Dependent from coverage at any time.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- What document(s) you may review to learn about the types of medical care and prescription drugs covered and not covered, how coverage decisions are made and how you may appeal those decisions, and other important plan information.

The following Attachment(s) to this Plan describe medical and prescription drug benefits and contain important information on covered and excluded services, cost-sharing, claims procedures, and your rights and responsibilities under the Plan:

Attachment	Title	Issuer/Administrator
1	Plan Guide 2024, UnitedHealthcare Group MedicareAdvantage Plan Group No. 13796 (Base Plan) and 13797 (Enhanced Plan)	UnitedHealthcare

SECTION 4 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

As a Retiree you may elect to terminate coverage under this Plan either for yourself and/or any eligible Dependents at any time; however, coverage will continue through the end of the month in which the benefit change form is submitted to the UM System Office of Human Resources. Coverage may not be reinstated at a later date unless you suspended your coverage under a University Retiree/LTD Recipient Medical Plan (or the predecessors of such plans) prior to January 1, 2017, in order to enroll in a non-University medical insurance plan or on or before January 1, 2018, in order to enroll as a Dependent on your Spouse's or Sponsored Adult Dependent's University Active Employee Plan (or a predecessor of such plan).

Notwithstanding the foregoing, if your coverage under this Plan is "frozen" as a result of your reemployment with the University and eligibility for coverage under a University Active Employee Medical Plan, coverage under this Plan will be reinstated (provided you immediately elect to reinstate your coverage under this Plan in accordance with *How to Enroll* in Section 2, *Introduction*) if you terminate such employment.

Entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the University will still pay claims for covered health services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Plan coverage will terminate and entitlement to Benefits will end for Covered Persons upon the first to occur of the following:

- the last day of the month in which:
    - the Covered Person ceases to meet the eligibility requirements described in *Eligibility* in Section 2, *Introduction*;
    - UnitedHealthcare receives written notice from the University to end coverage, or the date requested in the notice, if later;
    - the Covered Person is away from UnitedHealthcare's service area, including living abroad, for more than 6 months;
    - the Covered Person becomes incarcerated; or
    - the Plan and UnitedHealthcare determine the Covered Person has continuously behaved in a way that is disruptive and makes it difficult to provide medical care.(UnitedHealthcare will seek permission from Medicareprior to terminating your coverage for these reasons.)

- the end of the period for which required after-tax Contributions have been paid; or
- the date the Plan terminates.

Unless the provisions described below in "*Continuation of Medical Coverage for Dependents After the Death of a Retiree/LTD Recipient*" apply, coverage will also terminate for a Covered Person who is a Dependent on the last day of the month in which the Participant is no longer a Covered Person under this Plan or another University Retiree/LTD Recipient Medical Plan or University Active Employee Medical Plan.

Other Events Ending Your Coverage

Coverage may be rescinded if you commit an act, practice, or omission that constitutes fraud, or make an intentional misrepresentation of material fact with respect to coverage under this Plan, including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or dependent status or failing to timely provide required documentation evidencing proof of relationship or loss of coverage (if applicable) (see Section 2, *Eligibility* for more information). UnitedHealthcare will seek permission from Medicare prior to terminating your coverage for these reasons. The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice. The Plan will provide 31 days advance written notice to each affected individual before coverage is rescinded.

For the purpose of this Plan, rescinded means a retroactive cancellation or discontinuance of coverage of Benefits provided under this Plan, but does not include a cancellation or discontinuance of coverage if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required Contributions towards the cost of coverage.

Note: If UnitedHealthcare or the University find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact (which includes failure to timely provide required documentation evidencing proof of relationship or loss of coverage), the University has the right to demand that you pay back all Benefits the University paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Medicare Eligible Disabled Child

If an unmarried, enrolled Dependent Child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the Child, as long as:

- The Child is incapable of self-sustaining employment due to a mental or physical disability prior to reaching the maximum age; and
- The Child receives Principal Financial Support from you or your Spouse; and

- You provide application for continuation of Dependent status for such a Child and proof of the Child's incapacity and dependency to the University within thirty-one (31) days of the date coverage would have otherwise ended because the Child reached the maximum age; and

- You provide proof, upon the University's request, that the Child continues to meet these conditions.

To be eligible for continuation of Dependent status once the Child has reached the maximum age, the Child must be covered as a Dependent as defined in this Plan on the day immediately preceding the day the Child reaches the maximum age. If you fail to submit proof, coverage shall be discontinued at the end of the month in which the Dependent attains maximum age.

The University has the right to require proof of the continuation of disability upon attainment of such age as often as deemed necessary; however, you will not be asked to provide proof more than once a year. Proof includes:

- Social Security Benefit Verification Letter; or

- Completion of Physician Certification Form for the most recent calendar year, listing the child as a dependent.

If you do not supply such proof within thirty-one (31) days of being requested, the Plan will no longer pay Benefits for that Child. The University reserves the right to request a medical examination at the University's expense.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuation of Medical Coverage for Dependents After the Death of a Retiree/LTD Recipient

If you die after retirement or while receiving LTD benefits from the University, your Surviving Spouse or Surviving Sponsored Adult Dependent may continue coverage under this Plan, including for your eligible Children, after your death subject to the payment of monthly Contributions by your Surviving Spouse or Surviving Sponsored Adult Dependent. However, coverage under this Plan for your Children is available only to the extent your Surviving Spouse or Surviving Sponsored Adult Dependent remains covered under this Plan or another University Retiree/LTD Recipient Medical Plan.

It is important to note that the coverage for the Surviving Spouse or Surviving Sponsored Adult Dependent of a Retiree/LTD Recipient is available only to the person to whom the Retiree/LTD Recipient was married or had an affidavit of Adult Sponsored partnership with the University on the date of the Retiree's/LTD Recipient's death (and to whom the Retiree (but not the LTD Recipient) was married to or had a partnership with at the time of retirement). Additionally, continued coverage under this Plan is available only to Dependent Children covered at the time of the Retiree's/LTD Recipient's death. For the sake of clarity, coverage under this Plan is not available for the new spouse or partner of a Surviving Spouse or Surviving Sponsored Adult Dependent or for new dependent children born to, adopted by, or acquired through marriage by the Surviving Spouse or Surviving Sponsored Adult Dependent after the Retiree's/LTD Recipient's death, regardless of whether such dependent child is biologically related to the Retiree/LTD Recipient. The

subsidized level of Premiums will be somewhat different for Surviving Spouses and Surviving Adult Sponsored Dependents in that the Surviving Spouse or Surviving Adult Sponsored Dependent will be responsible for a larger portion of the cost (see *Cost of Coverage* in Section 2, *Introduction*). Eligibility under this Plan will depend on the Surviving Spouse's or Surviving Sponsored Adult Dependent's eligibility.

Enrollment for continued coverage under this Plan must be made within 31 days after the Retiree's/LTD Recipient's death.

Continued coverage under this Plan will terminate for any Dependent on the earliest of the following dates:

- The date the individual no longer meets this Plan's definition of an eligible Dependent.
- The date the Surviving Spouse or Surviving Sponsored Adult Dependent is no longer covered under this Plan.
- The date all Dependent coverage is discontinued under this Plan with respect to either Retirees or LTD Recipients.
- The end period for which the required Contributions have been made.

SECTION 5 - GLOSSARY

What this section includes:
Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Annual Enrollment - the period of time, determined by the University, during which eligible Participants may enroll or change Plans and/or decrease their coverage level for themselves and their Dependents. The University determines the period of time that is the Annual Enrollment period. Retirees/LTD Recipients will receive detailed information regarding Annual Enrollment from The UM System Office of Human Resources notifying them of plan changes for the upcoming calendar year. Enrollments during Annual Enrollment will be effective the following January 1.

Benefits - Plan payments for covered health services, subject to the terms and conditions of the Plan and any Attachments thereto.

Child or Children -

- natural children; or
- stepchildren (note that the child of a Retiree's/LTD Recipient's Sponsored Adult Dependent is not a stepchild); or
- foster children (subject to court order or placement by an authorized agency); or
- legally adopted children or children placed in the Retiree's/LTD Recipient's home for adoption (subject to court order); or
- each child, who otherwise meets the definition of "Child" under the Plan, of a Retiree/LTD Recipient for whom the University has received a valid Notice of Order to Enroll and for which the University is obligated to comply under Senate Bill No. 253 which repeals various Sections of RSMO 1986 and RSMO Supp. 1992; or
- each Child who a court has lawfully appointed the Employee (and/or the Employee's legal Spouse) as a legal guardian (legal guardianship) who is responsible for providing Principal Financial Support provided the:
    - Child is unmarried,
    - Child resides full-time with the Employee in parent-child relationship,
    - Child is declared a dependent on the Employee's federal income tax return; and
    - legal guardianship was awarded prior to the child's 18th birthday and is still in effect.
        - Legal guardianship ends on the child's 18th birthday, unless there is a court order extending the guardianship.

Dependent Children must meet additional requirements, as specified in the definition of Dependent, in order to be eligible to participate in this Plan.

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA Administrator – ASI COBRA, LLC.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal lawthat requires employers to offer continued health insurance coverage to certain Retirees/LTD Recipients and their dependents whose group health insurance has beenterminated.

Contributions - the amount designated by the University from time to time that Retirees/LTD Recipients and Qualified Beneficiaries are required to pay in order to receive Benefits under this Plan. The University may change these amounts at itsdiscretion subject to prior notification to the Participants.

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person, unless context suggests otherwise.

Dependent -

- the Spouse of a Retiree/LTD Recipient;
- each Child of a Retiree/LTD Recipient through the end of the month such Child reaches maximum age including: step-children, foster children, adopted children, or a child placed in your home for adoption;
- each Child who a court has lawfully appointed the Employee (and/or the Employee's legal Spouse) as a legal guardian (legal guardianship) who is responsible for providing Principal Financial Support provided the:
    - Child is unmarried,
    - Child resides full-time with the Employee in parent-child relationship,
    - Child is declared a dependent on the Employee's federal income tax return; and
    - legal guardianship was awarded prior to the child's 18th birthday and is still in effect.
        - Legal guardianship ends on the child's 18th birthday, unless there is a court order extending the guardianship.
- each unmarried Child of a Retiree/LTD Recipient who is mentally or physically incapable of self-sustaining employment prior to reaching the maximum age and who is dependent on you or your Spouse for Principal Financial Support.

  Application for continuation of Dependent status for such a Child and proof of the Child's status must be made with the University 31 days prior to the Child's attaining

such maximum age. The University has the right to require proof of the continuation of such disability upon attainment of such age as often as deemed necessary by the University. If the Retiree/LTD Recipient fails to submit such proof, coverage shall be discontinued at the end of the month in which the Dependent attains maximum age.

This definition shall be effective January 1, 1994 and shall not be construed to eliminate the eligibility of any Dependent covered by the Plan as of December 31, 1993.

To be eligible for continuation of Dependent status once an individual has reached the maximum age, the individual must be covered as a Dependent as defined in this Plan on the day immediately preceding the day the individual reaches the maximum age.

- the Sponsored Adult Dependent of a Retiree/LTD Recipient, so long as the Retiree/LTD Recipient does not have a Spouse.

- a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

A Dependent does not include anyone who is also enrolled as a Participant. No one can be aDependent of more than one Participant.

Disability Benefit Commencement Date – The date you begin receiving monthly benefits under the University of Missouri Long-Term Disability Plan (typically 149 calendar days after you have been totally disabled).

Domestic Partnership- see Sponsored Adult Dependent Partnership

Employer - The Curators of the University of Missouri.

Long-Term Disability Recipient (LTD Recipient)- an individual who while covered as an "employee" (as defined in University Collected Rules and Regulations (CRR) 310.020 and CRR 320.050), became totally and permanently disabled in accordance with the University's Long-Term Disability Plan and who is entitled to continued service credit (*i.e.* vested) as a disabled employee under the University's Retirement, Disability and Death Benefit Plan, or, effective January 1, 2020, who has been a benefit eligible employee for the five consecutive years immediately preceding the date on which the employee became totally and permanently disabled.

Marketplace - a competitive marketplace established under § 1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange or a Health Insurance Marketplace.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Participant – a Retired Employee or LTD Recipient of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2,

Introduction. References to "member" throughout this SPD are references to a Participant.

Plan - The Curators of the University of Missouri Group Medicare Advantage PPO Plan.

Plan Administrator - The Curators of the University of Missouri or its designee.

Plan Sponsor - The Curators of the University Of Missouri.

Plan Year - the twelve month period ending each December 31.

Premium - the monthly fee required from the Employer on behalf of each Participant and each enrolled Dependent in accordance with the terms of the Plan (including Attachments).

Principal Financial Support – a Retiree/LTD Recipient, during the calendar year is continuously providing more than one half of the total support of a Child, including the amountspent to provide food, lodging, clothing, education, medical, dental and vision care, recreation, transportation and similar necessities.

Qualified Beneficiary - a Participant or a covered Dependent of a Participant covered under this Plan on the day prior to a COBRA qualifying event. To the extent required by law, Qualified Beneficiary will also mean a Child born to the Retiree/LTD Recipient, or placed for adoption with the Retiree/LTD Recipient, during a period of continuation coverage**.**

Qualified Health Plan - an insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as "minimum essential coverage."

Qualified Medical Child Support Order (QMCSO) - a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

Retired Employee - see Retiree.

Retiree - any individual, other than a "subsidiary employee" (as defined by CRR 320.050), who terminates coverage under a University Active Employee Medical Plan, and on the date following such termination of coverage is eligible for early retirement, normal retirement, or disability retirement benefits under the terms and provisions of the University of Missouri Retirement, Disability and Death Benefit Plan. A Retiree shall also mean an individual who is either:

- in phased retirement under the terms and provisions of the University of Missouri Retirement, Disability and Death Benefit Plan; or
- a Surviving Spouse/Surviving Sponsored Adult Dependent.

Sickness - physical illness, disease or pregnancy. The term Sickness as used in this SPD includes mental illness or substance-related and addictive disorders, regardless of the cause or origin of the mental illness or substance-related and addictive disorder.

Sponsored Adult Dependent – a person of the same or opposite sex with whom the Participant has a relationship and with whom the Participant has established a Sponsored Adult Dependent Partnership.

Sponsored Adult Dependent Partnership - also commonly known as Domestic Partnership, is a relationship between a Participant and one other person of the same or opposite sex who meets all of the following criteria:

- Has had a single dedicated relationship of at least twelve (12) months with the Employee;
- Has had the same principal residence as the Retiree/LTD Recipient for at least 12 months, and continues to have the same principal residence as the Retiree/LTD Recipient disregarding temporaryabsences due to special circumstances including Sickness, education, business, vacation or military service;
- Is eighteen (18) years of age or older;
- Is not currently married to another person under either statutory or common law;
- Is not related to the Retiree/LTD Recipient by blood or degree of closeness that would prohibit marriage in the law of the state in which the Retiree/LTD Recipient resides; and
- has not been determined by a court or physician to be mentally incompetent.

Spouse - The legal Spouse of a Retiree/LTD Recipient, other than a deceased Retiree/LTD Recipient (see the defined term "Surviving Spouse", below), excluding a divorced Spouse or a Spouse separated by contract or decree from the Retiree/LTD Recipient.

Surviving Sponsored Adult Dependent -

- the Sponsored Adult Dependent of a Retiree who dies on or after January 1, 1970; and who is in a Sponsored Adult Dependent Partnership with the Retiree (i) on the date immediately preceding the Retiree's retirement; and (ii) on the date of the Retiree's death;
- the Sponsored Adult Dependent of a LTD Recipient who dies on or after January 1, 1970 and who, at the time the individual became totally and permanently disabled, was vested in the University of Missouri Retirement, Disability and Death Benefit Plan (having completed at least five years of creditable service), or would have been vested if covered by the University of Missouri Retirement, Disability and Death Benefit Plan instead of the Civil Service plan, Federal Employee Retirement plan or the Missouri State Retirement plan, or, effective January 1, 2020, who was a benefit eligible employee for the five consecutive years immediately preceding the date on which the employee became totally and permanently disabled; and who is in a Sponsored Adult Dependent Partnership with the LTD Recipient on the date of the LTD Recipient's death; or
- the Sponsored Adult Dependent of an active employee who dies while actively employed by the University on or after January 1, 1970 and who, at the time of death, was a vested member of the University of Missouri Retirement, Disability and Death Benefit Plan (having completed at least five years of creditable service), or who would have been vested if covered by the University of Missouri Retirement, Disability and Death Benefit Plan instead of the Civil Service plan, Federal Employee

Retirement plan or the Missouri State Retirement plan, or, effective January 1, 2020, who was a benefit eligible employee for the five consecutive years immediately preceding the Employee's death; and who is in a Sponsored Adult Dependent Partnership with the active employee (i) on the date of the active Employee's death; and (ii) for at least one year preceding death.

Surviving Spouse -

- a Spouse covered as a Surviving Spouse under the policy of group insurance which is superseded by this Plan on March 31, 1963 in accordance with the provisions of said policy in effect on said date; or
- the Spouse of a Retiree who dies on or after January 1, 1970, and who is married to a Retiree (i) on the date immediately preceding the Retiree's retirement; and (ii) on the date of the Retiree's death;
- the Spouse of a LTD Recipient who dies on or after January 1, 1970 and who, at the time the individual became totally and permanently disabled, was vested in the University of Missouri Retirement, Disability and Death Benefit Plan (having completed at least five years of creditable service), or would have been vested if covered by the University of Missouri Retirement, Disability and Death Benefit Planinstead of the Civil Service plan, Federal Employee Retirement plan or the Missouri State Retirement plan, or, effective January 1, 2020, who was a benefit eligible employee for the five consecutive years immediately preceding the date on which theemployee became totally and permanently disabled; and who is married to a LTD Recipient on the date of the LTD Recipient's death; or
- the Spouse of an active employee who dies while actively employed by the University on or after January 1, 1970 and who, at the time of death, was a vested member of the University of Missouri Retirement, Disability and Death Benefit Plan (having completed at least five years of creditable service), or who would have been vested if covered by the University of Missouri Retirement, Disability and Death Benefit Plan instead of the Civil Service plan, Federal Employee Retirement plan or the Missouri State Retirement plan, or, effective January 1, 2020, who was a benefit eligible employee for the five consecutive years immediately preceding the Employee's death; and who is married to the active employee (i) on the date of the active Employee's death; and (ii) for at least one year preceding death.

The University - The Curators of the University of Missouri, a public corporation, including all of its divisions, branches and parts.

University Active Employee Medical Plan – one of the following plans sponsored by the University:

- The Curators of the University of Missouri PPO Plan
- The Curators of the University of Missouri Healthy Savings Plan
- The Curators of the University of Missouri Custom Network Plan

University Retiree/LTD Recipient Medical Plan – one of the following plans sponsored by the University:

- The Curators of the University of Missouri Retiree and Disability Health PPO Plan

- The Curators of the University of Missouri Retiree and Disability Healthy Savings Plan
- The Curators of the University of Missouri Group Medicare Advantage PPO Plan (this Plan)

2025 Plan Guide

The Curators of the University of Missouri

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Number: 13796, 13797

Effective: January 1, 2025 through December 31, 2025

United Healthcare®
Group Medicare Advantage

With a UnitedHealthcare® Group Medicare Advantage plan, you get more

The University of Missouri (UM) has selected UnitedHealthcare® to provide health care and prescription drug coverage to their Medicare-eligible retirees. UM and UnitedHealthcare have worked closely together to create 2 plan options designed just for eligible UM retirees and their dependents — a Base Plan (Group number 13796) and an Enhanced Plan (Group number 13797). Both plan options are UnitedHealthcare Group Medicare Advantage (PPO) plans. The Base Plan has improved features. The Enhanced Plan, which may have higher premiums, provides coverage comparable to a Medicare Supplement Plan F.

Read through this Plan Guide to get to know your plan options

The guide includes:

- A description of the plans and how they work
- Information about benefits, programs and services, and how much they cost
- Information about covered drugs and how much they cost
- What you can expect after your enrollment

Please keep this Plan Guide. It has information that will be helpful once you become a member. You can also get plan information at the website below.

How to enroll

Simply follow the enrollment instructions provided by UM to indicate your plan selection. Submit the request to UM before your enrollment deadline. Once UM receives your enrollment selection and all other required information, UM will submit your enrollment to UnitedHealthcare for processing.

Important plan information

Before deciding to opt out, make sure you understand what it means for you if you decline this coverage. UM's eligibility rules may not allow you to re-enroll in a University-sponsored medical plan at a later date. Contact UM at **1-800-488-5288** for more information.

retiree.uhc.com/umsystem

Call toll-free **1-866-899-5903,** TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

More than health insurance

With these plans you get medical and prescription drug coverage and so much more. More benefits. More savings. More experience. More choices. More convenience.

Here's just some of what the plans offer

- **$0 copay** for home-delivered meals, transportation to medical appointments and the pharmacy, and non-medical personal care to assist with daily activities after a hospital or skilled nursing facility stay
- **Earn rewards** to spend on eligible items like gifts, clothing, groceries and more
- **Free delivery with Optum® Home Delivery Pharmacy** for prescriptions you take regularly
- **Free standard gym membership** at participating locations
- **Free UnitedHealthcare® HouseCalls visit** from one of our licensed health care practitioners
- **Free hearing exam** and $500 allowance to spend on a broad selection of hearing aids
- **Virtual doctor and behavioral health visits** using your computer, tablet or smartphone – anytime, day or night
- **Medicare Advantage's largest national provider network**
- **Special programs to help you** if you are living with a chronic disease, like diabetes or heart disease, or other complex health needs
- **Free diabetic supplies** like continuous glucose monitors, needles and test strips

Review the Summary of Benefits in this guide for more details

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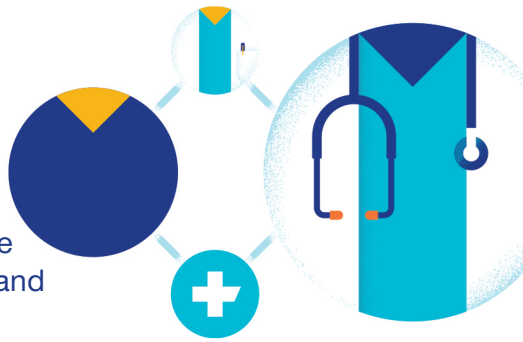
More from your health plan



These PPO plans are Medicare Advantage plans, also known as Medicare Part C. They have all the benefits of Medicare Part A (hospital coverage) and Medicare Part B (doctor and outpatient care) plus extra programs that go beyond Original Medicare (Medicare Parts A and B). Medicare has rules about what types of coverage you can add or combine with a group-sponsored Medicare Advantage plan.

Here's how these PPO plans work

Get care from providers in or out-of-network as long as they accept Medicare and the plan

No referral is needed to see a specialist or other provider

Select a primary care provider (PCP) to oversee and help manage your care
It's not required, but it's very beneficial for your long-term health and well-being.

You pay a standard copay or coinsurance to see a network or out-of-network provider
We work closely with our network (contracted) providers to make sure they have access to resources and tools to help them work with you for better health outcomes.

These plans have separate maximum annual out-of-pocket amounts for medical and prescription drugs
If you reach your plan's medical limit, the plan will pay 100% of your Medicare-covered services for the rest of the plan year. After you and others on your behalf have paid a combined total of $2,000 for your prescription drugs, you won't pay anything for your Medicare-covered Part D drugs for the rest of the calendar year.

Emergency and urgently needed services are covered anywhere in the world

These plans include prescription drug coverage for thousands of brand name and generic drugs
Always use network pharmacies for your plan's lowest cost on prescription drugs.

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

Scan this code to view the Drug List

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Get to know your plan

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

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

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

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

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

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

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

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

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

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

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

Summary of Benefits 2025

UnitedHealthcare® Group Medicare Advantage (PPO)
Group Name (Plan Sponsor): The Curators of the University of Missouri
Group Number: 13796
H2001-816-000

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

retiree.uhc.com/umsystem

Toll-free **1-866-899-5903**, TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

United Healthcare®
Group Medicare Advantage

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Summary of Benefits

January 1, 2025 - December 31, 2025

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

UnitedHealthcare® Group Medicare Advantage (PPO)

Medical premium, deductible and limits	
	In-network and out-of-network
Monthly plan premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Annual medical deductible	Your plan has an annual combined in-network and out-of-network medical deductible of $300 each plan year.
Maximum out-of-pocket amount (does not include prescription drugs)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $3,400 for this plan year. If you reach the limit on out-of-pocket costs, you keep getting covered for hospital and medical services and we will pay the full cost for the rest of the plan year. Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.

Medical benefits		
		In-network and out-of-network
Inpatient hospital care[1]		$200 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital[1]	Ambulatory surgical center (ASC)	$100 copay

Medical benefits		
		In-network and out-of-network
Cost sharing for additional plan covered services will apply.	Outpatient surgery	$100 copay
	Outpatient hospital services, including observation	$100 copay
Doctor visits	Primary care provider (PCP)	$10 copay
	Virtual visit	$0 copay
	Specialist[1]	$20 copay
Preventive services	Routine physical	$0 copay; 1 per plan year*
	Medicare-covered	$0 copay

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings and monitoring
- Diabetes – Self-Management training
- Dialysis training
- Glaucoma screening
- Hepatitis C screening
- HIV screening
- Kidney disease education
- Lung cancer with low dose computed tomography (LDCT) screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screenings and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)

Medical benefits		
		In-network and out-of-network
	▯ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19 ▯ "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100%.	
Emergency care		$65 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently needed services		$35 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the urgently needed services copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (e.g. MRI, CT scan)[1]	$25 copay
	Lab services[1]	$0 copay
	Diagnostic tests and procedures[1]	$50 copay
	Therapeutic radiology[1]	$25 copay
	Outpatient X-rays[1]	$0 copay
Hearing services	Exam to diagnose and treat hearing and balance issues[1]	$20 copay
	Routine hearing exam	$0 copay, 1 exam per plan year*

Medical benefits		
		In-network and out-of-network
	Hearing Aids UnitedHealthcare Hearing	Through UnitedHealthcare Hearing, the plan pays a $500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.
Vision services	Exam to diagnose and treat diseases and conditions of the eye[1]	$20 copay
	Eyewear after cataract surgery	$0 copay
	Routine eye exam	$0 copay, 1 exam every 12 months*
Mental health	Inpatient visit[1]	$200 copay per stay, up to 190 days
		Our plan covers 190 days for an inpatient hospital stay.
	Outpatient group therapy visit[1]	$10 copay
	Outpatient individual therapy visit[1]	$20 copay
	Outpatient therapy or office visit with a psychiatrist[1]	$20 copay
	Virtual behavioral visits	$20 copay
Skilled nursing facility (SNF)[1]		$0 copay per day: days 1-20 $50 copay per day: days 21-100
		Our plan covers up to 100 days in a SNF per benefit period.
Outpatient Rehabilitation (physical, occupational, or speech/language therapy)[1]		$25 copay
Ambulance[2]		$50 copay

Medical benefits		
		In-network and out-of-network
Routine transportation		Not covered
Medicare Part B Drugs Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	Chemotherapy drugs[1]	20% coinsurance
	Other Part B drugs[1]	20% coinsurance

Good news for 2025

The Coverage Gap, or “donut hole”, has been eliminated and your out-of-pocket limit (the amount you and others on your behalf pay) is $2,000. That means you're more protected from high drug costs in 2025.

Prescription drugs	
Deductible	$520 You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage.
Initial coverage	In this stage, you’ll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,000, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage.

Prescription drugs		
Tier drug coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing** **31-day supply**	**Mail Order Cost-Sharing** **90-day supply**
Tier 1: Preferred Generic	20% coinsurance, with a $7 copay minimum	20% coinsurance, with a $15 copay minimum
Tier 2: Preferred Brand ~	20% coinsurance, with a $15 copay minimum	20% coinsurance, with a $30 copay minimum
Tier 3: Non-preferred Drug ~	50% coinsurance, with a $30 copay minimum	50% coinsurance, with a $60 copay minimum
Tier 4: Specialty Tier ~	25% coinsurance	25% coinsurance
Catastrophic coverage	Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.	

~ Subject to Medicare guidance, coinsurance may not apply to Part D insulin products. You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible. Most adult Part D vaccines are covered at no cost to you.

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

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

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

You may qualify for Extra Help from Medicare

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

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

The UnitedHealthcare Savings Promise

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

Additional benefits		
		In-network and out-of-network
Acupuncture services	Medicare-covered acupuncture (for chronic low back pain)	$20 copay
Chiropractic services	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[1]	$20 copay
	Routine chiropractic services	20% coinsurance, up to 12 visits per plan year*
Diabetes management	Diabetes monitoring supplies[1]	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView. Other brands are not covered by your plan.
	Medicare covered Continuous Glucose Monitors (CGMs) and supplies[1]	$0 copay

Additional benefits		
		In-network and out-of-network
	Diabetes self-management training	$0 copay
	Therapeutic shoes or inserts[1]	20% coinsurance
Durable medical equipment (DME) and related supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs)[1]	20% coinsurance
Fitness program SilverSneakers®		$0 copay for SilverSneakers®, a health and fitness program designed for Medicare plan members. It includes a standard monthly membership at participating fitness locations plus online classes, workshops and more. Call or go online to learn more and to get your SilverSneakers ID number. 1-888-338-1722, TTY 711 or SilverSneakers.com/StartHere.
Foot care (podiatry services)	Foot exams and treatment[1]	$20 copay
	Routine foot care	$20 copay, 6 visits per plan year*
UnitedHealthcare Healthy at Home Post-discharge program		$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay: □28 home-delivered meals, referral required □12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required □6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required Services must be provided by approved vendors. Call Customer Service for more information, to request a referral after each discharge and to use your benefits.

Additional benefits		
		In-network and out-of-network
Home health care[1]		$0 copay
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
Opioid treatment program services[1]		$0 copay
Outpatient substance use disorder services	Outpatient group therapy visit[1]	$10 copay
	Outpatient individual therapy visit[1]	$20 copay
Renal dialysis[1]		20% coinsurance

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

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

*Benefits are combined in and out-of-network

About this plan

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

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

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

About providers and network pharmacies

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies and other providers. You can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare program. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **retiree.uhc.com/umsystem** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

Required Information

UnitedHealthcare® Group Medicare Advantage (PPO) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

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

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

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

You must continue to pay your Medicare Part B premium.

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

Always talk with your doctor before starting an exercise program.

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

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Summary of Benefits 2025

UnitedHealthcare® Group Medicare Advantage (PPO)
Group Name (Plan Sponsor): The Curators of the University of Missouri
Group Number: 13797
H2001-816-000

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

retiree.uhc.com/umsystem

Toll-free **1-866-899-5903**, TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

United Healthcare®
Group Medicare Advantage

Y0066_SB_H2001_816_000_2025_M

Summary of Benefits

January 1, 2025 - December 31, 2025

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

UnitedHealthcare® Group Medicare Advantage (PPO)

Medical premium and limits	
	In-network and out-of-network
Monthly plan premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Maximum out-of-pocket amount (does not include prescription drugs)	$0 for Medicare-covered services from any provider If you reach the limit on out-of-pocket costs, you keep getting covered for hospital and medical services and we will pay the full cost for the rest of the plan year. Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.

Medical benefits		
		In-network and out-of-network
Inpatient hospital care[1]		$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital[1] Cost sharing for additional plan	Ambulatory surgical center (ASC)	$0 copay
	Outpatient surgery	$0 copay

Medical benefits		
		In-network and out-of-network
covered services will apply.	Outpatient hospital services, including observation	$0 copay
Doctor visits	Primary care provider (PCP)	$0 copay
	Virtual visit	$0 copay
	Specialist[1]	$0 copay
Preventive services	Routine physical	$0 copay; 1 per plan year*
	Medicare-covered	$0 copay

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings and monitoring
- Diabetes – Self-Management training
- Dialysis training
- Glaucoma screening
- Hepatitis C screening
- HIV screening
- Kidney disease education
- Lung cancer with low dose computed tomography (LDCT) screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screenings and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screenings and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19
- “Welcome to Medicare” preventive visit (one-time)

Medical benefits		
		In-network and out-of-network
	Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100%.	
Emergency care		$0 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently needed services		$0 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the urgently needed services copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (e.g. MRI, CT scan)[1]	$0 copay
	Lab services[1]	$0 copay
	Diagnostic tests and procedures[1]	$0 copay
	Therapeutic radiology[1]	$0 copay
	Outpatient X-rays[1]	$0 copay
Hearing services	Exam to diagnose and treat hearing and balance issues[1]	$0 copay
	Routine hearing exam	$0 copay, 1 exam per plan year*

Medical benefits		
		In-network and out-of-network
	Hearing Aids UnitedHealthcare Hearing	Through UnitedHealthcare Hearing, the plan pays a $500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.
Vision services	Exam to diagnose and treat diseases and conditions of the eye[1]	$0 copay
	Eyewear after cataract surgery	$0 copay
	Routine eye exam	$0 copay, 1 exam every 12 months*
Mental health	Inpatient visit[1]	$0 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
	Outpatient group therapy visit[1]	$0 copay
	Outpatient individual therapy visit[1]	$0 copay
	Outpatient therapy or office visit with a psychiatrist[1]	$0 copay
	Virtual behavioral visits	$0 copay
Skilled nursing facility (SNF)[1]		$0 copay per day: days 1-20 $0 copay per day: days 21-100
		Our plan covers up to 100 days in a SNF per benefit period.
Outpatient Rehabilitation (physical, occupational, or speech/language therapy)[1]		$0 copay
Ambulance[2]		$0 copay

Medical benefits		
		In-network and out-of-network
Routine transportation		Not covered
Medicare Part B Drugs Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	Chemotherapy drugs[1]	$0 copay
	Other Part B drugs[1]	$0 copay

Good news for 2025

The Coverage Gap, or “donut hole”, has been eliminated and your out-of-pocket limit (the amount you and others on your behalf pay) is $2,000. That means you're more protected from high drug costs in 2025.

Prescription drugs	
Deductible	$520 You pay the full cost for your drugs until you reach the deductible amount. Then you move to the Initial Coverage stage.
Initial coverage	In this stage, you’ll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of $2,000, which includes the amount you paid towards your deductible, you move to the Catastrophic Coverage stage.

Prescription drugs		
Tier drug coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing** **31-day supply**	**Mail Order Cost-Sharing** **90-day supply**
Tier 1: Preferred Generic	20% coinsurance, with a $7 copay minimum	20% coinsurance, with a $15 copay minimum
Tier 2: Preferred Brand ~	20% coinsurance, with a $15 copay minimum	20% coinsurance, with a $30 copay minimum
Tier 3: Non-preferred Drug ~	50% coinsurance, with a $30 copay minimum	50% coinsurance, with a $60 copay minimum
Tier 4: Specialty Tier ~	25% coinsurance	25% coinsurance
Catastrophic coverage	Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year. If your plan includes additional prescription drug coverage, you will continue to pay the cost-sharing amounts from the Initial Coverage stage for those drugs. Please see your Additional Drug Coverage list for more information.	

~ Subject to Medicare guidance, coinsurance may not apply to Part D insulin products. You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan even if you haven't paid your Part D deductible. Most adult Part D vaccines are covered at no cost to you.

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

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

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

You may qualify for Extra Help from Medicare

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

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

The UnitedHealthcare Savings Promise

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

Additional benefits		
		In-network and out-of-network
Acupuncture services	Medicare-covered acupuncture (for chronic low back pain)	$0 copay
Chiropractic services	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[1]	$0 copay
	Routine chiropractic services	$0 copay, up to 12 visits per plan year*
Diabetes management	Diabetes monitoring supplies[1]	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch® Ultra 2, Accu-Chek® Guide Me and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus and Accu-Chek® SmartView. Other brands are not covered by your plan.
	Medicare covered Continuous Glucose Monitors (CGMs) and supplies[1]	$0 copay

Additional benefits		
		In-network and out-of-network
	Diabetes self-management training	$0 copay
	Therapeutic shoes or inserts[1]	$0 copay
Durable medical equipment (DME) and related supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	$0 copay
	Prosthetics (e.g., braces, artificial limbs)[1]	$0 copay
Fitness program SilverSneakers®		$0 copay for SilverSneakers®, a health and fitness program designed for Medicare plan members. It includes a standard monthly membership at participating fitness locations plus online classes, workshops and more. Call or go online to learn more and to get your SilverSneakers ID number. 1-888-338-1722, TTY 711 or SilverSneakers.com/StartHere.
Foot care (podiatry services)	Foot exams and treatment[1]	$0 copay
	Routine foot care	$0 copay, 6 visits per plan year*
UnitedHealthcare Healthy at Home Post-discharge program		$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay: □28 home-delivered meals, referral required □12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required □6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required Services must be provided by approved vendors. Call Customer Service for more information, to request a referral after each discharge and to use your benefits.

Additional benefits		
		In-network and out-of-network
Home health care[1]		$0 copay
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
Opioid treatment program services[1]		$0 copay
Outpatient substance use disorder services	Outpatient group therapy visit[1]	$0 copay
	Outpatient individual therapy visit[1]	$0 copay
Renal dialysis[1]		$0 copay

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

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

*Benefits are combined in and out-of-network

About this plan

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

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

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

About providers and network pharmacies

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies and other providers. You can see any provider (network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare program. If you use pharmacies that are not in our network, the plan may not pay for those drugs, or you may pay more than you pay at a network pharmacy.

You can go to **retiree.uhc.com/umsystem** to search for a network provider or pharmacy using the online directories. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

Required Information

UnitedHealthcare® Group Medicare Advantage (PPO) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C and Part D benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

You must continue to pay your Medicare Part B premium.

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Additional Drug Coverage

This is not a complete list of prescription drugs and supplies available to you. The prescription drugs and supplies on this list are covered in addition to the plan's Drug List (Formulary). You can find the plan's Drug List on your member site or scan the QR code at the end of this Additional Drug Coverage section.

Bonus drug list

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

Bold type = Brand name drug Plain type = Generic drug

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

Bold type = Brand name drug Plain type = Generic drug

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

Bold type = Brand name drug Plain type = Generic drug

Covered drugs are placed in tiers. Each tier may have a different cost. See the Summary of Benefits to find out what you'll pay for these drugs.

Although you pay the same copay for these drugs as shown in the Summary of Benefits and Evidence of Coverage, the amount you pay for these additional prescription drugs **does not apply to your Medicare Part D out-of-pocket costs.** Payments for these additional prescription drugs (made by you or the plan) are treated differently from payments made for other prescription drugs.

Coverage for the prescription drugs on the bonus drug list is in addition to your Medicare prescription drug coverage under the plan. Unlike your Medicare prescription drug coverage under the plan, you are unable to file a Medicare appeal or grievance for drugs on the bonus drug list.

If you get Extra Help from Medicare to pay for your prescription drugs, it will not apply to the drugs on this bonus drug list.

If your drug has any coverage rules or limits, there will be code(s) in the "Coverage rules or limits on use" column of the chart. The codes and what they mean are shown below.

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

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

7D - 7-day limit
An opioid drug used to treat pain may be limited to a 7-day supply if you don't have a recent history of using opioids. This limit helps minimize long-term opioid use. If you are new to the plan and have a recent history of using opioids, the pharmacy may override the limit when appropriate.

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

Scan this code to view the Drug List

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

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Here's what you can expect next

Once you're a member, the UnitedHealthcare Customer Service team and your online account make it easier to get the care you need, when and how you need it.

You are here
UnitedHealthcare will process your enrollment

Create your account to review your plan online

Receive your member ID card in the mail

Coverage begins! Start using your plan

Manage your plan online

Use your Medicare number or member ID number to create an account at **retiree.uhc.com/umsystem**. Online you can:

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

Once your coverage begins

- Schedule your annual wellness visit
- Get a yearly in-home visit with UnitedHealthcare® HouseCalls. Visit **uhchousecalls.com** to learn more
- Get the medications you take regularly through Optum® Home Delivery Pharmacy

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

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

Thank you for trusting UnitedHealthcare with your health care coverage

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

Scan this code to access the member site

Statements of understanding

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

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

Nondiscrimination notice

Discrimination is against the law. The company complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes.

If you believe you were treated unfairly because of your race, color, national origin, age, disability, or sex, you can send a grievance to our Civil Rights Coordinator.

- **Email:** **UHC_Civil_Rights@uhc.com**
- **Mail:** Civil Rights Coordinator
  UnitedHealthcare Civil Rights Grievance
  P.O. Box 30608, Salt Lake City, UT 84130

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

- **Online:** **https://www.hhs.gov/civil-rights/filing-a-complaint/index.html**
- **Phone:** Toll-free **1-800-368-1019**, **800-537-7697** (TDD)
- **Mail:** U.S. Department of Health and Human Services
  200 Independence Ave SW, HHH Building, Room 509F
  Washington, D.C. 20201

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free phone number on your member identification card or listed on the cover of the booklet (TTY **711**).

This notice is available at
https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, please call us using the toll-free number on your member identification card or listed on the cover of the booklet. Someone who speaks your language can help you. This is a free service.

Spanish: Contamos con servicios gratuitos de intérprete para responder cualquier pregunta que pudiera tener sobre nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al número de teléfono gratuito que figura en su tarjeta de identificación de miembro o en la portada del folleto. Una persona que habla su idioma podrá ayudarle. Es un servicio gratuito.

Chinese Mandarin: 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡或手冊封面列出的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

Chinese Cantonese: 我們提供免費的口譯服務，可回答您可能對我們的健康或藥物計劃的任何問題。如需口譯員，請撥打您的會員識別卡或手冊封面列出的免付費電話號碼聯絡我們。會說您的語言的人可協助您。這是免費服務。

Tagalog: Mayroon kaming libreng serbisyo ng interpreter para sagutin anumang tanong na maaaring mayroon ka tungkol sa kalusugan o plano ng gamot. Para makakuha ng interpreter, pakitawagan kami gamit ang libreng numero na nasa iyong kard ng pagkakakilanlan ng kasapi o nakalista sa pabalat ng booklet. Sinumang nagsasalita ng wika mo ay puwedeng makatulong sa iyo. Ang serbisyong ito ay libre.

French: Nous disposons de services d'interprétation gratuits pour répondre à toutes les questions que vous pourriez vous poser sur notre régime d'assurance maladie ou d'assurance-médicaments. Pour recevoir l'aide d'un interprète, veuillez nous appeler en composant le numéro gratuit figurant sur votre carte d'identification de membre ou sur la première de couverture de la brochure. Quelqu'un parlant votre langue peut vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi mà bạn có về chương trình bảo hiểm sức khoẻ hay thuốc của chúng tôi. Để gặp thông dịch viên, vui lòng gọi cho chúng tôi theo số điện thoại miễn phí trên thẻ nhận dạng hội viên của bạn hoặc ghi trên bìa của quyển sách nhỏ. Người nói cùng ngôn ngữ với bạn có thể giúp bạn. Đây là dịch vụ miễn phí.

German: Wir verfügen über kostenlose Dolmetscherdienste, um alle Fragen zu beantworten, die Sie über unseren Gesundheits- oder Medikamentenplan haben mögen. Um einen Dolmetscher zu erhalten, rufen Sie uns bitte unter der kostenfreien Nummer an, die auf Ihrem Mitgliedsausweis oder auf dem Umschlag der Broschüre aufgeführt ist. Jemand, der Ihre Sprache spricht, kann Ihnen helfen. Dies ist eine kostenlose Dienstleistung.

Korean: 건강 또는 의약품 플랜에 관한 질문에 답변해드리기 위해 무료 통역 서비스를 제공합니다. 통역 서비스를 이용하려면, 가입자 ID 카드 또는 이 소책자 표지에 나와 있는 수신자 부담 전화번호로 전화해 주십시오. 한국어를 사용하는 통역사가 도움을 드릴 수 있습니다. 이 서비스는 무료입니다.

Russian: Если у Вас возникнут какие-либо вопросы о нашем плане медицинского страхования или плане по приобретению препаратов, мы предоставим Вам бесплатные услуги устного перевода. Для того чтобы воспользоваться услугами устного перевода, пожалуйста, свяжитесь с нами по бесплатному номеру телефона, указанному на Вашей идентификационной карте участника плана или спереди на буклете. Сотрудник, который говорит на Вашем языке, сможет Вам помочь. Данная услуга предоставляется бесплатно.

Arabic: لدينا خدمات ترجمة فورية للرد على أي أسئلة قد تكون لديك حول الخطة الصحية أو خطة الأدوية الخاصة بنا. للحصول على مترجم، اتصل بنا باستخدام رقم الهاتف المجاني على بطاقة تعريف عضويتك أو على غلاف الكتيب. سيساعدك شخص ما يتحدث لغتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा प्लान के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएं मौजूद हैं। दुभाषिया पाने के लिए, कृपया अपने सदस्य पहचान पत्र पर या पुस्तिका के अग्रभाग पर सूचीबद्ध टोल-फ्री नंबर का उपयोग करके हमें कॉल करें। आपकी भाषा बोलने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Italian: Mettiamo a disposizione un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario o farmaceutico. Per avvalersi di un interprete, si prega di chiamare il numero verde riportato sulla tessera identificativa o indicato sulla copertina dell'opuscolo. Una persona che parla italiano potrà fornire l'assistenza richiesta. Il servizio è gratuito.

Portuguese: Dispomos de serviços de intérprete gratuitos para esclarecer quaisquer dúvidas que tenha sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número gratuito no seu cartão de identificação de membro ou indicado na parte da frente do folheto. Alguém que fala a sua língua pode ajudá-lo(a). Este é um serviço gratuito.

French Creole: Nou gen sèvis entèprèt gratis pou reponn tout kesyon ou gendwa genyen konsènan plan sante oswa medikaman nou an. Pou jwenn yon entèprèt, tanpri rele nou apati nimewo apèl gratis ki sou kat idantifikasyon manm ou an oswa ki endike sou kouvèti ti liv la. Yon moun ki pale lang ou ka ede ou. Sa se yon sèvis gratis.

Polish: Oferujemy bezpłatne usługi tłumaczeniowe, aby odpowiedzieć na wszelkie pytania dotyczące naszego planu ubezpieczenia zdrowotnego lub planu refundacji leków. Aby skorzystać z pomocy tłumacza, proszę zadzwonić pod bezpłatny numer telefonu podany na Pana/Pani karcie identyfikacyjnej lub na okładce broszury. Osoba posługująca się Pana/Pani językiem Panu/Pani pomoże. Usługa ta jest bezpłatna.

Japanese: 当社の医療または処方薬プランに関する質問にお答えするために、無料の通訳サービスをご利用いただけます。通訳が必要な場合には、会員 ID カードまたは本冊子の表紙に記載されているフリーダイヤル番号を使用して、当社までお問い合わせください。お客様の言語を話す通訳者がお手伝いいたします。これは無料のサービスです。

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