



# 2026 Plan Guide

## **UHC Feds PSHB Retiree Advantage Plan**

UnitedHealthcare® Group Medicare Advantage (PPO)

**Group Number:** 15976, 25685

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

United  
Healthcare®  
Group Medicare Advantage

# Postal Retirees, the choice is yours

As part of the Postal Service Health Benefits (PSHB) Program, all Medicare-eligible retirees will automatically get Medicare Part D prescription drug coverage through their PSHB plan.

UnitedHealthcare offers 2 plan options under the PSHB Program for you to choose from:

- **Retiree Advantage Plan** – A Group Medicare Advantage plan that includes Part D prescription drug coverage
- **MedicareRx Part D Plan (PDP)** – A stand-alone prescription drug plan that works alongside the Choice Plus PSHB Medical Plan

There's no additional premium for either of these plans.



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

The guide includes:

- A comparison chart to learn more about your plan options
- Information about benefits, programs and services
- Information about covered drugs and how much they cost

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



## How to enroll

### Retiree Advantage Plan

If you want to enroll in the Retiree Advantage Plan, please call us at the toll-free number below. If you choose to enroll in this plan, don't suspend your coverage with the Office of Personnel Management (OPM). If you do, you'll be automatically disenrolled from the Retiree Advantage Plan.

### MedicareRx PDP with the Choice Plus PSHB Medical plan

If you don't enroll in the Retiree Advantage Plan, you'll be automatically enrolled in this Part D prescription drug plan. It will replace your current prescription drug coverage, starting on the plan's effective date.

**If you don't want to be enrolled in the Retiree Advantage plan or the MedicareRx PDP plan,** please call us at the toll-free number below to opt-out. If you choose to opt-out you won't receive pharmacy benefits from the Postal Service Health Benefit (PSHB) Program. You won't be able to enroll in the MedicareRx PDP plan again until the next Open Season.



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




Call toll-free **1-844-481-8821**, TTY **711**  
8 a.m.-8 p.m. local time, Monday-Friday

# Compare your retirement plan choices

Postal retirees, when you enroll in Medicare you have the choice between the UnitedHealthcare Feds PSHB Retiree Advantage plan or being auto-enrolled into the MedicareRx (PDP) Part D prescription drug plan alongside your Choice Plus PSHB medical benefits. Please see the chart below for a side by side comparison of the plan choices available for you to choose from.



 <b>Medical benefits</b>	<b>Choice Plus PSHB Medical with MedicareRx Part D Prescriptions</b>	<b>Retiree Advantage with Part D Prescriptions</b>
<b>Annual medical deductible</b>	\$750	None
<b>Annual medical out-of-pocket maximum</b>	\$7,350	None
<b>Physician visits (primary care or virtual)</b>	\$0	\$0
<b>Preventive services</b>	\$0	\$0
<b>Specialist office visit</b>	\$60	\$0
<b>Inpatient hospital</b>	20% after deductible	\$0
<b>Outpatient hospital</b>	20% after deductible	\$0
<b>Emergency room and ambulance</b>	20% after deductible	\$0
<b>Urgent care</b>	\$60	\$0
<b>Physical and occupational therapy</b>	20% after deductible 60 visit limit combined	\$0 no visit limit
<b>Durable medical equipment</b>	20% after deductible	\$0
<b>Diabetic supplies</b>	20% after deductible	\$0
<b>Routine podiatry — 6 per year</b>	Not covered	\$0
<b>Hearing aids</b>	20% after deductible \$2,500 allowance	\$0 \$1,500 allowance



## Pharmacy benefits

	Choice Plus PSHB Medical with MedicareRx Part D Prescriptions	Retiree Advantage with Part D Prescriptions
<b>Part D Prescriptions</b>	Yes	Yes
<b>Deductible</b>	\$0	\$0
<b>Out-of-pocket max</b>	\$2,100	\$2,100
<b>Retail pharmacy</b>		
<b>Tier 1</b>	\$10	\$5
<b>Tier 2</b>	\$45	\$25
<b>Tier 3</b>	\$100	\$60
<b>Tier 4</b>	\$100	\$90
<b>Mail order pharmacy</b>		
<b>90 day supply</b>	2.5 times retail copay	2 times retail copay



## Plan highlights

	Choice Plus PSHB Medical with MedicareRx Part D Prescriptions	Retiree Advantage with Part D Prescriptions
<b>National network</b>	✓	✓
<b>Dental coverage (preventive care only, \$500 annual max)</b>	✓	✓
<b>Remain in the PSHB program</b>	✓	✓
<b>Worldwide coverage</b>		✓
<b>One plan — no need to coordinate benefits</b>		✓

## Plus, these extras that only come with Retiree Advantage

**\$150**

Monthly Part B  
premium subsidy



Free gym  
membership

**\$100**

Per year vision  
eyewear allowance



Post-discharge  
home-delivered meals

**\$40**

Quarterly credit for  
over-the-counter items



Optum®  
HouseCalls

You must continue to pay your UnitedHealthcare Choice Plus PSHB premium if you elect to enroll in the Retiree Advantage plan, but there is no additional premium for the Retiree Advantage plan.



[retiree.uhc.com/postal](https://retiree.uhc.com/postal)



**1-844-481-8821, TTY 711**

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

### Important information

#### Enrollment information

As a part of the PSHBP (Postal Service Health Benefits Program), you will be automatically enrolled into the UnitedHealthcare MedicareRx (PDP) Part D prescription drug plan for your prescription drug benefits **unless** you choose to opt into the UnitedHealthcare Feds PSHB Retiree Advantage (PPO) plan, which includes Part D prescription drugs.

If you elect to enroll in the Retiree Advantage plan it will take over as the primary and only payer so you will not need to coordinate benefits, however, you must remain enrolled in the Choice Plus PSHB plan and continue to pay that plan premium if you elect the Retiree Advantage plan. Do not suspend or cancel your coverage with OPM or you will also be terminated from the Retiree Advantage plan.

#### Disenrollment Information

As a part of the PSHBP (Postal Service Health Benefits Program), you will be automatically enrolled into the UnitedHealthcare MedicareRx (PDP) Part D prescription drug plan for your prescription drug benefits **unless** you choose to opt in to the UnitedHealthcare Feds PSHB Retiree Advantage (PPO) plan, which includes Part D prescription drugs.

**If you opt out or disenroll from the UnitedHealthcare MedicareRX (PDP) and do not elect to enroll in the UnitedHealthcare Feds PSHB Retiree Advantage plan, your premium will not change and you will no longer have prescription drug coverage through the PSHB program, until next Open Season.**

If you enroll in the Retiree Advantage plan and find that it's not the right fit, you can disenroll at any time.

If you disenroll from the Retiree Advantage plan you will be moved back to Original Medicare primary with the Choice Plus PSHB Health Plan secondary for medical, and auto-enrolled into the MedicareRX (PDP) plan for prescription benefits.

### **Medicare Part B enrollment**

In most cases, if you retire after January 1, 2025 you must enroll in Medicare Part B when you are first eligible to continue retiree coverage in the PSHB Program. Having Medicare Part B makes you eligible for the Retiree Advantage plan. You must continue paying your Medicare Part B premium to be eligible for the UnitedHealthcare Feds PSHB Retiree Advantage plan. If you stop paying your Medicare Part B premium, you may be disenrolled from PSHB coverage.

### **Medicare Part B Late Enrollment Penalty (LEP)**

If you didn't get Medicare Part B when you were first eligible, your monthly premium may go up. In most cases, you'll have to pay this penalty each time you pay your premiums, for as long as you have Medicare Part B. You must continue paying your Medicare Part B premium to be eligible for coverage under the PSHB program. If you stop paying your Medicare Part B premium, you may be disenrolled from this plan.

### **Medicare Part D Late Enrollment Penalty (LEP)**

Once you become a MedicareRx (PDP) or Retiree Advantage plan member, you will receive a letter to confirm you have had continuous prescription drug coverage. If you had coverage through the UnitedHealthcare FEHB or PSHB health plan or another FEHB or PSHB plan since you became Medicare eligible, you had what is known as "creditable coverage" and a penalty will not apply. You simply need to respond to the letter as quickly as possible to avoid an unnecessary penalty.

### **Income-Related Monthly Adjustment Amount (IRMAA)**

IRMAA is an amount Social Security determines you may need to pay in addition to your monthly Part B and D premium if your modified adjusted gross income on your IRS tax return from 2 years ago is above a certain limit. The MedicareRx (PDP) plan and Retiree Advantage plan's included prescription drug coverage is considered Part D coverage. Therefore if you currently have a Part B IRMAA, then you may incur a Part D IRMAA when enrolling in either of these plans.

### **Copay cards**

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

### **Call Social Security to see if you qualify for Extra Help**

If you have a limited income, you may be able to get Extra Help to pay for your prescription drug costs. Many people qualify and don't know it. There's no penalty for applying, and you can re-apply every year. Call toll-free at **1-800-772-1213**, TTY **1-800-325-0778**, 8 a.m.–7 p.m., Monday–Friday.

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

Allowance for unlimited aids every 3 years. Allowance is combined for both ears.

Combined medical & pharmacy out-of-pocket max

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

This information is not a complete description of benefits. Contact the plan for more information. Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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# Summary of Benefits 2026

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

Group Name (Plan Sponsor): UHC Feds PSHB Retiree Advantage Plan

Group Number: 15976

H1537-843-000

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



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**United  
Healthcare®**  
Group Medicare Advantage

# Summary of Benefits


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

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can see it online at [retiree.uhc.com/postal](http://retiree.uhc.com/postal) or you can call Customer Service for help. When you enroll in the plan, you will get more information on how to view your plan details online.

## UnitedHealthcare® Group Medicare Advantage (PPO)

Deductible and limits		
		In-network and out-of-network
<b>Part B premium reduction</b>		\$150.00
<b>Maximum out-of-pocket amount</b> (does not include prescription drugs)		\$0 for Medicare-covered services from any provider  Please note that you will still need to pay your cost-sharing for your Part D prescription drugs.
Medical benefits		
		In-network and out-of-network
<b>Inpatient hospital care<sup>1</sup></b>		\$0 copay per stay  Our plan covers an unlimited number of days for an inpatient hospital stay.
<b>Outpatient hospital<sup>1</sup></b>	Ambulatory surgical center (ASC)	\$0 copay
	Outpatient surgery	\$0 copay
	Outpatient hospital services, including observation	\$0 copay

## Medical benefits

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


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%.

## Medical benefits

		In-network and out-of-network
<b>Emergency care</b>		<p>\$0 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>
<b>Urgently needed services</b>		<p>\$0 copay (worldwide)</p> <p>If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the urgently needed services copay. See the “Inpatient Hospital Care” section of this booklet for other costs.</p>
<b>Diagnostic tests, lab and radiology services, and X-rays</b>	Diagnostic radiology services (e.g. MRI, CT scan) <sup>1</sup>	\$0 copay
	Lab services <sup>1</sup>	\$0 copay
	Diagnostic tests and procedures <sup>1</sup>	\$0 copay
	Therapeutic radiology <sup>1</sup>	\$0 copay
	Outpatient X-rays <sup>1</sup>	\$0 copay
<b>Hearing services</b>	Exam to diagnose and treat hearing and balance issues <sup>1</sup>	\$0 copay
	Routine hearing exam	\$0 copay, 1 exam per plan year*
	Hearing Aids UnitedHealthcare Hearing	Through UnitedHealthcare Hearing, the plan pays a \$1,500 allowance for hearing aids (combined for both ears) every 3 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.

## Medical benefits

		In-network and out-of-network
 <b>Vision services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup>	\$0 copay
	Eyewear after cataract surgery	\$0 copay
	Routine eye exam	\$0 copay, 1 exam every 12 months *
	Routine eyewear	Plan pays up to \$100 for eyeglasses, or up to \$100 for contact lenses instead of eyeglasses, every 12 months.*
<b>Mental health</b>	Inpatient visit <sup>1</sup>	\$0 copay per stay  Our plan covers an unlimited number of days for an inpatient hospital stay.
	Outpatient group therapy visit <sup>1</sup>	\$0 copay
	Outpatient individual therapy visit <sup>1</sup>	\$0 copay
	Outpatient therapy or office visit with a psychiatrist <sup>1</sup>	\$0 copay
	Virtual behavioral visits	\$0 copay
<b>Skilled nursing facility (SNF)<sup>1</sup></b>		\$0 copay per day: days 1-20 \$0 copay per day: days 21-100  Our plan covers up to 100 days in a SNF per benefit period.
<b>Outpatient Rehabilitation (physical, occupational, or speech/language therapy)<sup>1</sup></b>		\$0 copay
<b>Ambulance<sup>2</sup></b>		\$0 copay

Medical benefits			
		In-network and out-of-network	
<b>Ambulance, No Transport (Non-Medicare-Covered)</b>		\$0 copay	
<b>Routine transportation</b>		Not covered	
<b>Medicare Part B Drugs</b>	Chemotherapy drugs <sup>1</sup>	\$0 copay	
Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	Other Part B drugs <sup>1</sup>	\$0 copay	
Prescription drugs			
<b>Deductible</b>		The plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.	
<b>Initial coverage</b>		In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,100 you move to the Catastrophic Coverage stage.	
<b>Tier drug coverage</b> (After you pay your deductible, if applicable)		<b>Retail Cost-Sharing</b>	<b>Mail Order Cost-Sharing</b>
		<b>30-day supply</b>	<b>90-day supply</b>
<b>Tier 1:</b> Preferred Generic		\$5 copay	\$10 copay
<b>Tier 2:</b> Preferred Brand ~		\$25 copay	\$50 copay
<b>Tier 3:</b> Non-Preferred Drug ~		\$60 copay	\$120 copay
<b>Tier 4:</b> Specialty Tier ~		\$90 copay	\$180 copay
<b>Catastrophic coverage</b>		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.	

## Prescription drugs

~ You will pay a maximum of \$35 for a 1-month supply of each Part D insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.

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

UHC Feds PSHB Retiree Advantage Plan offers drug coverage in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D benefit and your additional drug coverage. For more information, see your Additional Drug Coverage list. You can also view the Certificate of Coverage at [retiree.uhc.com/postal](http://retiree.uhc.com/postal) or call Customer Service to have a hard copy sent to you.

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

**\$0**

### You may qualify for Extra Help from Medicare


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

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




## Additional benefits

		In-network and out-of-network
<b>Acupuncture services</b>	Medicare-covered acupuncture (for chronic low back pain)	\$0 copay
	Routine acupuncture services	\$0 copay, up to 12 visits per plan year*
<b>Chiropractic services</b>	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>1</sup>	\$0 copay

## Additional benefits

	In-network and out-of-network	
	Routine chiropractic services	\$0 copay, up to 20 visits per plan year*
 <b>Diabetes management</b>	Diabetes monitoring supplies <sup>1</sup>	<p>\$0 copay</p> <p>We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.</p> <p>Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.</p> <p>Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.</p>
	Medicare covered Continuous Glucose Monitors (CGMs) and supplies <sup>1</sup>	\$0 copay
	Diabetes self-management training	\$0 copay
	Therapeutic shoes or inserts <sup>1</sup>	\$0 copay
<b>Durable medical equipment (DME) and related supplies</b>	Durable Medical Equipment (e.g., wheelchairs, oxygen) <sup>1</sup>	\$0 copay
	Prosthetics (e.g., braces, artificial limbs) <sup>1</sup>	\$0 copay
	Wigs	\$0 copay for wigs for hair loss due to chemotherapy*

## Additional benefits

		In-network and out-of-network
	<b>Fitness program</b> Renew Active by UnitedHealthcare	<p>\$0 copay for Renew Active by UnitedHealthcare, a Medicare fitness program. It includes a gym membership at a fitness location you select from our national network, plus online classes and fun activities outside of the gym, at no additional cost.</p> <p>Show your UnitedHealthcare UCard® to access your free membership the first time you visit a network gym or fitness location. Call or go online to learn more.</p>
<b>Foot care (podiatry services)</b>	Foot exams and treatment <sup>1</sup>	\$0 copay
	Routine foot care	\$0 copay, 6 visits per plan year*
<b>Over-the-counter (OTC) credit</b>		\$40 credit each quarter to buy covered OTC products from network retail locations or through the website. Credits expire the last day of each quarter.
	<b>UnitedHealthcare Healthy at Home</b> Post-discharge program	<p>\$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 28 home-delivered meals, referral required</li> <li><input type="checkbox"/> 12 one-way trips to medically related appointments and the pharmacy, up to 50 miles per trip, referral required</li> <li><input type="checkbox"/> 6 hours of non-medical personal care services like companionship, meal prep, medication reminders and more with a professional caregiver, no referral required</li> </ul> <p>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.</p>
	<b>Home health care<sup>1</sup></b>	\$0 copay
<b>Hospice</b>		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
<b>Opioid treatment program services<sup>1</sup></b>		\$0 copay

## Additional benefits

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

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

<sup>2</sup> Authorization is required for non-emergency Medicare-covered ambulance air transportation. Authorization is not required for non-emergency Medicare-covered ambulance ground transportation. Emergency ambulance (ground or air) does not require authorization.

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

## About this plan

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

## Required Information

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

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

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

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

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

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

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

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

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

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

You must continue to pay your Medicare Part B premium.

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

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

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

policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. Gym network may vary in local market and plan.

# Additional Drug Coverage

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

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



## Lower-cost Medicare prescription drugs and supplies

The following drugs have a \$0 copay.

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

Lovastatin (20mg Tablet)	Enalapril (20mg Tablet)
Lovastatin (40mg Tablet)	Fosinopril (10mg Tablet)
Rosuvastatin (5mg Tablet)	Fosinopril (20mg Tablet)
Rosuvastatin (10mg Tablet)	Fosinopril (40mg Tablet)
Rosuvastatin (20mg Tablet)	Lisinopril (2.5mg Tablet)
Rosuvastatin (40mg Tablet)	Lisinopril (5mg Tablet)
Pravastatin (10mg Tablet)	Lisinopril (10mg Tablet)
Pravastatin (20mg Tablet)	Lisinopril (20mg Tablet)
Pravastatin (40mg Tablet)	Lisinopril (30mg Tablet)
Pravastatin (80mg Tablet)	Lisinopril (40mg Tablet)
Simvastatin (5mg Tablet)	Moexipril (7.5mg Tablet)
Simvastatin (10mg Tablet)	Moexipril (15mg Tablet)
Simvastatin (20mg Tablet)	Quinapril (5mg Tablet)
Simvastatin (40mg Tablet)	Quinapril (10mg Tablet)
Simvastatin (80mg Tablet)	Quinapril (20mg Tablet)
Glimepiride (1mg Tablet)	Quinapril (40mg Tablet)
Glimepiride (2mg Tablet)	Ramipril (1.25mg Capsule)
Glimepiride (4mg Tablet)	Ramipril (2.5mg Capsule)
Glipizide (5mg Tablet)	Ramipril (5mg Capsule)
Glipizide (10mg Tablet)	Ramipril (10mg Capsule)
Glipizide (ER & XL 2.5mg Tablet)	Trandolapril (1mg Tablet)
Glipizide (ER & XL 5mg Tablet)	Trandolapril (2mg Tablet)
Glipizide (ER & XL 10mg Tablet)	Trandolapril (4mg Tablet)
Metformin (500mg Tablet)	Irbesartan (75mg Tablet)
Metformin (850mg Tablet)	Irbesartan (150mg Tablet)
Metformin (1000mg Tablet)	Irbesartan (300mg Tablet)
Metformin (500mg ER Tablet)(generic Glucophage XR)	Losartan (25mg Tablet)
Metformin (750mg ER Tablet)(generic Glucophage XR)	Losartan (50mg Tablet)
Repaglinide (0.5mg Tablet)	Losartan (100mg Tablet)
Repaglinide (1mg Tablet)	Olmesartan (5mg Tablet)
Repaglinide (2mg Tablet)	Olmesartan (20mg Tablet)
Pioglitazone (15mg Tablet)	Olmesartan (40mg Tablet)
Pioglitazone (30mg Tablet)	Telmisartan (20mg Tablet)
Pioglitazone (45mg Tablet)	Telmisartan (40mg Tablet)
Benazepril (5mg Tablet)	Telmisartan (80mg Tablet)
Benazepril (10mg Tablet)	Valsartan (40mg Tablet)
Benazepril (20mg Tablet)	Valsartan (80mg Tablet)
Benazepril (40mg Tablet)	Valsartan (160mg Tablet)
Enalapril (2.5mg Tablet)	Valsartan (320mg Tablet)
Enalapril (5mg Tablet)	Amlodipine/Benazepril (2.5-10mg Capsule)
Enalapril (10mg Tablet)	Amlodipine/Benazepril (5-10mg Capsule)
	Amlodipine/Benazepril (5-20mg Capsule)
	Amlodipine/Benazepril (5-40mg Capsule)

Amlodipine/Benazepril (10-20mg Capsule)	Losartan/Hydrochlorothiazide (50-12.5mg Tablet)
Amlodipine/Benazepril (10-40mg Capsule)	Losartan/Hydrochlorothiazide (100-12.5mg Tablet)
Enalapril/Hydrochlorothiazide (5-12.5mg Tablet)	Losartan/Hydrochlorothiazide (100-25mg Tablet)
Enalapril/Hydrochlorothiazide (10-25mg Tablet)	Olmesartan/Hydrochlorothiazide (20-12.5mg Tablet)
Lisinopril/Hydrochlorothiazide (10-12.5mg Tablet)	Olmesartan/Hydrochlorothiazide (40-12.5mg Tablet)
Lisinopril/Hydrochlorothiazide (20-12.5mg Tablet)	Olmesartan/Hydrochlorothiazide (40-25mg Tablet)
Lisinopril/Hydrochlorothiazide (20-25mg Tablet)	Valsartan/Hydrochlorothiazide (80-12.5mg Tablet)
Quinapril/Hydrochlorothiazide (10-12.5mg Tablet)	Valsartan/Hydrochlorothiazide (160-12.5mg Tablet)
Quinapril/Hydrochlorothiazide (20-12.5mg Tablet)	Valsartan/Hydrochlorothiazide (160-25mg Tablet)
Quinapril/Hydrochlorothiazide (20-25mg Tablet)	Valsartan/Hydrochlorothiazide (320-12.5mg Tablet)
Amlodipine/Olmesartan (5-20mg Tablet)	Valsartan/Hydrochlorothiazide (320-25mg Tablet)
Amlodipine/Olmesartan (5-40mg Tablet)	
Amlodipine/Olmesartan (10-20mg Tablet)	
Amlodipine/Olmesartan (10-40mg Tablet)	
Irbesartan/Hydrochlorothiazide (150-12.5mg Tablet)	
Irbesartan/Hydrochlorothiazide (300-12.5mg Tablet)	

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

## Lower-cost non-Medicare prescription drugs

The following drugs have a \$0 copay.

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

### Colon Preparation Products

Bisacodyl (Tablet)

Bisacodyl (Suppository)

Magnesium Citrate (Solution)

Polyethylene Glycol (Powder)

### Blood Clot Prevention

Aspirin (Generic Only)

### Tobacco Cessation Medications

Nicotine (Gum)

Nicotine (Lozenges)

Nicotine (Patches)

**Vitamins**

Folic Acid (0.4mg, 0.8mg & 1mg Tablet)

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## Bonus drug list

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

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

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

Drug name	Drug tier	Coverage rules or limits on use
<b>Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions</b>		
<b>Inflammation</b>		
Salsalate	1	
<b>Urinary Tract Pain</b>		
Phenazopyridine	1	
<b>Anorexiant - drugs to promote weight loss</b>		
<b>Alli</b>	3	QL (maximum of 3 capsules per day)
Benzphetamine	1	QL (maximum of 3 tablets per day)
<b>Contrave</b>	3	QL (maximum of 4 tablets per day)
Diethylpropion (25 mg)	1	QL (maximum of 3 tablets per day)
Diethylpropion (75 mg ER)	1	QL (maximum of 1 tablet per day)
<b>Imcivree</b>	3	QL (maximum of 9 vials (9 mL) per 30 days)
Liraglutide	1	PA, QL (maximum of 5 pens per 30 days)
Phendimetrazine (35 mg)	1	QL (maximum of 6 tablets per day)
Phendimetrazine (105 mg ER)	1	QL (maximum of 2 capsules per day)
Phentermine	1	QL (maximum of 1 capsule/tablet per day)
Phentermine/Topiramate	1	QL (maximum of 1 capsule per day)
<b>Saxenda</b>	4	PA, QL (maximum of 5 pens per 30 days)
<b>Wegovy</b>	4	PA, QL (maximum of 4 pens per 28 days)

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

Drug name	Drug tier	Coverage rules or limits on use
<b>Zepbound</b>	4	PA, QL (maximum of 4 pens/vials per 28 days)
<b>Anticoagulants - drugs to prevent clotting</b>		
Heparin Lock Flush	1	
<b>Dermatological agents - drugs to treat skin conditions</b>		
<b>Dry, Itchy Skin</b>		
Sulfacetamide Sodium (Liquid Wash 10%)	1	
Sulfacetamide Sodium w/Sulfur (Cream 10-5%)	1	
<b>Itching Or Pain</b>		
Pramoxine/Hydrocortisone (Cream 1-2.5%)	1	
<b>Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions</b>		
<b>Hemorrhoids</b>		
Hydrocortisone Acetate (Suppository 25 mg)	1	
Lidocaine/Hydrocortisone (Perianal Cream 3%-0.5%)	1	
<b>Irritable Bowel Or Ulcers</b>		
Hyoscyamine Sulfate	1	
<b>Levbid</b>	3	
<b>Genitourinary agents - drugs to treat bladder, genital and kidney conditions</b>		
<b>Erectile Dysfunction</b>		
<b>Edex</b>	3	QL (maximum of 6 cartridges per month)
Avanafil	1	QL (maximum of 6 tablets per month)
Sildenafil (25 mg, 50 mg, 100 mg)	1	QL (maximum of 6 tablets per month)
Tadalafil	1	QL (maximum of 6 tablets per month)
Vardenafil	1	QL (maximum of 6 tablets per month)
<b>Sexual Desire Disorder</b>		
<b>Addyi</b>	3	QL (maximum of 1 tablet per day)

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

Drug name	Drug tier	Coverage rules or limits on use
<b>Vyleesi</b>	3	QL (maximum of 8 injections per 30 days)
<b>Urinary Tract Infection</b>		
<b>Uro-MP (118 mg)</b>	3	
<b>Urinary Tract Spasm And Pain</b>		
Belladonna Alkaloids & Opium (Suppositories)	1	MME, 7D, DL
<b>Hormonal agents - hormone replacement/modifying drugs</b>		
<b>Thyroid Supplement</b>		
<b>Armour Thyroid</b>	3	
NP Thyroid	1	
<b>Nutritional supplements - drugs to treat vitamin &amp; mineral deficiencies</b>		
<b>Potassium Supplement</b>		
<b>K-Phos (Tab)</b>	3	
Potassium Bicarbonate (Effervescent Tab 25 mEq)	1	
<b>Vitamins And Minerals</b>		
Cyanocobalamin (Injection) (Vitamin B12) (1000 mcg)	1	
Folic Acid (1 mg) (Rx only)	1	
Folic Acid-Vitamin B6-Vitamin B12 (Tablet 2.5-25-1 mg)	1	
Phytonadione (Tab)	1	
Reno (Cap)	1	
Vitamin D (50,000 unit) (Rx only)	1	
<b>Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions</b>		
<b>Cough And Cold</b>		
Benzonatate (100 mg, 200 mg)	1	
Brompheniramine/Pseudoephedrine/Dextromethorphan (Syrup)	1	
Guaifenesin/Codeine (Syrup)	1	DL
Hydrocodone Polst/Chlorpheniramine (ER Susp) (generic for Tussionex)	1	DL

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

Drug name	Drug tier	Coverage rules or limits on use
Hydrocodone/Homatropine	1	DL
Promethazine/Codeine (Syrup)	1	DL
Promethazine/Dextromethorphan (Syrup)	1	

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

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

**QL - Quantity limits**

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

**MME - Morphine Milligram Equivalent**

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

**7D - 7-day limit**

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

**DL - Dispensing limit**

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

BDL: BDL - Custom FED

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.



# Summary of Benefits 2026

## **UnitedHealthcare Medicare Rx (PDP)**

Group Name (Plan Sponsor): UHC Feds PSHB Part D Prescription Drug Plan

Group Number: 25685

S5805-803-000

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



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



**Toll-free 1-844-481-8821, TTY 711**

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

**United  
Healthcare®**

Y0066\_SB\_S5805\_803\_000\_2026\_M

# Summary of Benefits

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

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can see it online at [retiree.uhc.com/postal](http://retiree.uhc.com/postal) or you can call Customer Service for help. When you enroll in the plan, you will get more information on how to view your plan details online.

## UnitedHealthcare Medicare Rx (PDP)

### Deductible and limits

**Annual prescription drug deductible** This plan does not have a deductible.

### Prescription drugs

**Deductible** The plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.

**Initial coverage** In this stage, you'll pay your plan copays or coinsurance. The plan pays the rest. Once you, and others on your behalf, have paid a combined total of \$2,100 you move to the Catastrophic Coverage stage.

**Tier drug coverage**  
(After you pay your deductible, if applicable)

#### Retail Cost-Sharing

#### Mail Order Cost-Sharing

#### 30-day supply

#### 90-day supply

**Tier 1:**  
Preferred Generic

\$10 copay

\$25 copay

**Tier 2:**  
Preferred Brand ~

\$45 copay

\$112.50 copay

**Tier 3:**  
Non-Preferred Drug ~

\$100 copay

\$250 copay

### Catastrophic coverage

Once you're in this stage, you won't pay anything for your Medicare-covered Part D drugs for the rest of the plan year.

~ You will pay a maximum of \$35 for a 1-month supply of each Part D insulin product covered by our plan. Most adult Part D vaccines are covered at no cost to you.

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

UHC Feds PSHB Part D Prescription Drug Plan offers drug coverage in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D benefit and your additional drug coverage. For more information, see your Additional Drug Coverage list. You can also view the Certificate of Coverage at [retiree.uhc.com/postal](https://retiree.uhc.com/postal) or call Customer Service to have a hard copy sent to you.

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

### **You may qualify for Extra Help from Medicare**

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

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

## About this plan

UnitedHealthcare Medicare Rx (PDP) is a Medicare Prescription Drug Plan with a Medicare contract.

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

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

## Use network pharmacies

UnitedHealthcare Medicare Rx (PDP) has a network of pharmacies. If you use out-of-network pharmacies, 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/postal](https://retiree.uhc.com/postal) to search for a network pharmacy using the online directory. You can also view the plan Drug List (Formulary) to see what drugs are covered and if there are any restrictions.

## Required Information

UnitedHealthcare Medicare Rx (PDP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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

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

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

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

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

Benefits and features vary by plan. Limitations and exclusions may apply.

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

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

You must continue to pay your Medicare Part B premium.

# Additional Drug Coverage

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

To see the complete Drug List, scan the QR code or visit

[retiree.uhc.com/postal](http://retiree.uhc.com/postal)



## Lower-cost Medicare prescription drugs and supplies

The following drugs have a \$0 copay.

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

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

## Lower-cost non-Medicare prescription drugs

The following drugs have a \$0 copay.

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

### Colon Preparation Products

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Bisacodyl (Tablet)

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Bisacodyl (Suppository)

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Magnesium Citrate (Solution)

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Polyethylene Glycol (Powder)

### Blood Clot Prevention

---

Aspirin (Generic Only)

### Tobacco Cessation Medications

---

Nicotine (Gum)

---

Nicotine (Lozenges)

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Nicotine (Patches)

### Vitamins

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Folic Acid (0.4mg, 0.8mg & 1mg Tablet)

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## Bonus drug list

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

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

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

Drug name	Drug tier	Coverage rules or limits on use
<b>Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions</b>		
<b>Inflammation</b>		
Salsalate	1	
<b>Urinary Tract Pain</b>		
Phenazopyridine	1	
<b>Anorexiant - drugs to promote weight loss</b>		
<b>Alli</b>	3	QL (maximum of 3 capsules per day)
Benzphetamine	1	QL (maximum of 3 tablets per day)
<b>Contrave</b>	3	QL (maximum of 4 tablets per day)
Diethylpropion (25 mg)	1	QL (maximum of 3 tablets per day)
Diethylpropion (75 mg ER)	1	QL (maximum of 1 tablet per day)
<b>Imcivree</b>	3	QL (maximum of 9 vials (9 mL) per 30 days)
Liraglutide	1	PA, QL (maximum of 5 pens per 30 days)
Phendimetrazine (35 mg)	1	QL (maximum of 6 tablets per day)
Phendimetrazine (105 mg ER)	1	QL (maximum of 2 capsules per day)
Phentermine	1	QL (maximum of 1 capsule/tablet per day)
Phentermine/Topiramate	1	QL (maximum of 1 capsule per day)
<b>Saxenda</b>	4	PA, QL (maximum of 5 pens per 30 days)
<b>Wegovy</b>	4	PA, QL (maximum of 4 pens per 28 days)

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

Drug name	Drug tier	Coverage rules or limits on use
<b>Zepbound</b>	4	PA, QL (maximum of 4 pens/vials per 28 days)
<b>Anticoagulants - drugs to prevent clotting</b>		
Heparin Lock Flush	1	
<b>Dermatological agents - drugs to treat skin conditions</b>		
<b>Dry, Itchy Skin</b>		
Sulfacetamide Sodium (Liquid Wash 10%)	1	
Sulfacetamide Sodium w/Sulfur (Cream 10-5%)	1	
<b>Itching Or Pain</b>		
Pramoxine/Hydrocortisone (Cream 1-2.5%)	1	
<b>Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions</b>		
<b>Hemorrhoids</b>		
Hydrocortisone Acetate (Suppository 25 mg)	1	
Lidocaine/Hydrocortisone (Perianal Cream 3%-0.5%)	1	
<b>Irritable Bowel Or Ulcers</b>		
Hyoscyamine Sulfate	1	
<b>Levbid</b>	3	
<b>Genitourinary agents - drugs to treat bladder, genital and kidney conditions</b>		
<b>Erectile Dysfunction</b>		
<b>Edex</b>	3	QL (maximum of 6 cartridges per month)
Avanafil	1	QL (maximum of 6 tablets per month)
Sildenafil (25 mg, 50 mg, 100 mg)	1	QL (maximum of 6 tablets per month)
Tadalafil	1	QL (maximum of 6 tablets per month)
Vardenafil	1	QL (maximum of 6 tablets per month)
<b>Sexual Desire Disorder</b>		
<b>Addyi</b>	3	QL (maximum of 1 tablet per day)

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

Drug name	Drug tier	Coverage rules or limits on use
<b>Vyleesi</b>	3	QL (maximum of 8 injections per 30 days)
<b>Urinary Tract Infection</b>		
<b>Uro-MP (118 mg)</b>	3	
<b>Urinary Tract Spasm And Pain</b>		
Belladonna Alkaloids & Opium (Suppositories)	1	MME, 7D, DL
<b>Hormonal agents - hormone replacement/modifying drugs</b>		
<b>Thyroid Supplement</b>		
<b>Armour Thyroid</b>	3	
NP Thyroid	1	
<b>Nutritional supplements - drugs to treat vitamin &amp; mineral deficiencies</b>		
<b>Potassium Supplement</b>		
<b>K-Phos (Tab)</b>	3	
Potassium Bicarbonate (Effervescent Tab 25 mEq)	1	
<b>Vitamins And Minerals</b>		
Cyanocobalamin (Injection) (Vitamin B12) (1000 mcg)	1	
Folic Acid (1 mg) (Rx only)	1	
Folic Acid-Vitamin B6-Vitamin B12 (Tablet 2.5-25-1 mg)	1	
Phytonadione (Tab)	1	
Reno (Cap)	1	
Vitamin D (50,000 unit) (Rx only)	1	
<b>Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions</b>		
<b>Cough And Cold</b>		
Benzonatate (100 mg, 200 mg)	1	
Brompheniramine/Pseudoephedrine/Dextromethorphan (Syrup)	1	
Guaifenesin/Codeine (Syrup)	1	DL
Hydrocodone Polst/Chlorpheniramine (ER Susp) (generic for Tussionex)	1	DL

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

Drug name	Drug tier	Coverage rules or limits on use
Hydrocodone/Homatropine	1	DL
Promethazine/Codeine (Syrup)	1	DL
Promethazine/Dextromethorphan (Syrup)	1	

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

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

**QL - Quantity limits**

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

**MME - Morphine Milligram Equivalent**

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

**7D - 7-day limit**

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

**DL - Dispensing limit**

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

BDL: BDL - Custom FED

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.

# Statements of understanding

**By enrolling in the Retiree Advantage Plan (PPO), I agree to the following:**

- ✓ **This is a Medicare Advantage Plan contracted with the federal government. This is not a Medicare Supplement Plan.**  
I need to keep my Medicare Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party. To be eligible for this plan, I must live in the plan's service area and be a United States citizen or be lawfully present in the U.S.
- ✓ **I must continue to pay my FEHBP or PSHBP premium and not cancel or suspend my FEHBP or PSHBP coverage with the Office of Personnel Management (OPM), or I will be disenrolled from this Medicare Advantage plan.**
- ✓ **The service area includes the 50 United States, the District of Columbia and all U.S. territories.**  
I 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.
- ✓ **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.

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

- ✓ **UnitedHealthcare® MedicareRx for Groups (PDP) is a Medicare Prescription Drug Plan and has a contract with the federal government.**  
This prescription drug coverage is in addition to my coverage under Medicare. I need to keep my Medicare Part A and/or Part B, and I must continue to pay my Medicare Part B premium if I have one, and if 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.
- ✓ **UnitedHealthcare MedicareRx for Groups (PDP) is available in all U.S. states, the District of Columbia and all U.S. territories.**  
I understand that I must use network pharmacies except in an emergency when I cannot use

the plan's network pharmacies.

 **I can only be in one Medicare Part D Prescription Drug Plan at a time.**

- By enrolling in this plan, I will automatically be disenrolled from any other Medicare Part D Prescription Drug Plan.
- Enrollment in this plan is generally 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 Part D Prescription Drug Plan.**

I understand that when my coverage begins, I must get all of my prescription drug benefits from the plan. Benefits and services provided by the plan and contained in the Evidence of Coverage (EOC) document will be covered. Neither Medicare nor the plan will pay for benefits or services that are not covered.

## Notice of nondiscrimination

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

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

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

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

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

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

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

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

Online: **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**

Phone: **1-800-368-1019, 800-537-7697** (TDD)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

















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