



Summary of Benefits 2026

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (Plan Sponsor): State Health Benefit Plan

Group Numbers: 12472, 12473, 12474, 12475

H2001-816-000

H2001-819-000

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/shbp



Toll-free **877-246-4190**, TTY **711**

8 a.m.–8 p.m. ET, Monday–Friday

**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/shbp 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)



Medical premium and limits	Standard plan In-network and out-of-network	Premium plan 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)	<p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$3,500 for this plan year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the plan year.</p> <p>Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.</p>	<p>Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of \$2,500 for this plan year.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the plan year.</p> <p>Please note that you will still need to pay your monthly premiums, if applicable, and cost-sharing for your Part D prescription drugs.</p>

Medical benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Inpatient hospital care¹		20% coinsurance per stay	20% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital¹ Cost sharing for additional plan covered services will apply.	Ambulatory surgical center (ASC)	\$95 copay	\$50 copay
	Outpatient surgery	\$95 copay	\$50 copay
	Outpatient hospital services, including observation	\$95 copay	\$50 copay
 Doctor visits	Primary care provider	\$25 copay	\$15 copay
	Virtual visit	\$0 copay	\$0 copay
	Specialist ¹	\$30 copay	\$25 copay

Medical benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Preventive services	Routine physical	\$0 copay, 1 per plan year*	\$0 copay, 1 per plan year*
	Medicare-covered	\$0 copay	\$0 copay
		<ul style="list-style-type: none"> • 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		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Preventive services (continued)	Medicare-covered	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		\$50 copay (worldwide) If you are admitted to the hospital within 72 hours, you pay the inpatient hospital care cost sharing instead of the emergency care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.	\$50 copay (worldwide) If you are admitted to the hospital within 72 hours, you pay the inpatient hospital care cost sharing instead of the emergency care copay. See the “Inpatient Hospital Care” section of this booklet for other costs.
Urgently needed services		\$25 copay (worldwide) If you are admitted to the hospital within 72 hours, you pay the inpatient hospital care cost sharing instead of the urgently needed services copay. See the “Inpatient Hospital Care” section of this booklet for other costs.	\$20 copay (worldwide) If you are admitted to the hospital within 72 hours, you pay the inpatient hospital care cost sharing instead of the urgently needed services copay. See the “Inpatient Hospital Care” section of this booklet for other costs.

Medical benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Diagnostic tests, lab and radiology services, and X-rays	Complex radiology services (e.g. MRI, CT scan) ¹	If a complex radiology service is performed and processed at a hospital or free-standing facility:	If a complex radiology service is performed and processed at a hospital or free-standing facility:
		20% coinsurance	20% coinsurance
		If a complex radiology service is performed and processed in a doctor's office:	If a complex radiology service is performed and processed in a doctor's office:
		\$35 copay	\$35 copay
	Lab services ¹	\$0 copay	\$0 copay
	Diagnostic tests and procedures ¹	If a diagnostic test is performed and processed at a hospital or free-standing facility:	If a diagnostic test is performed and processed at a hospital or free-standing facility:
		\$95 copay	\$50 copay
		If a diagnostic test is performed and processed in a doctor's office:	If a diagnostic test is performed and processed in a doctor's office:
		\$0 copay	\$0 copay
	Therapeutic radiology ¹	If a therapeutic radiology service is performed and processed at a hospital or free-standing facility:	If a therapeutic radiology service is performed and processed at a hospital or free-standing facility:
20% coinsurance		20% coinsurance	
If a therapeutic radiology service is performed and processed in a doctor's office:		If a therapeutic radiology service is performed and processed in a doctor's office:	
	\$35 copay	\$35 copay	
Outpatient X-rays ¹	\$0 copay	\$0 copay	

Medical benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
 Hearing services	Exam to diagnose and treat hearing and balance issues ¹	\$30 copay	\$25 copay
	Routine hearing exam	\$0 copay, 1 exam per plan year*	\$0 copay, 1 exam per plan year*
	Hearing aids	The plan pays up to a \$1,000 allowance for hearing aids (combined for both ears) every 4 years.*	The plan pays up to a \$1,000 allowance for hearing aids (combined for both ears) every 4 years.*
 Vision services	Exam to diagnose and treat diseases and conditions of the eye ¹	\$25 copay	\$15 copay
	Eyewear after cataract surgery	\$0 copay	\$0 copay
	Routine eye exam	\$0 copay, 1 exam every 12 months*	\$0 copay, 1 exam every 12 months*
	Routine eyewear	Plan pays up to \$125 combined allowance for eyeglasses and contact lenses every 12 months.*	Plan pays up to \$125 combined allowance for eyeglasses and contact lenses every 12 months.*
Mental health	Inpatient visit ¹	20% coinsurance per stay	20% coinsurance per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.	Our plan covers an unlimited number of days for an inpatient hospital stay.
	Outpatient group therapy visit ¹	\$30 copay	\$25 copay
	Outpatient individual therapy visit ¹	\$30 copay	\$25 copay
	Outpatient therapy or office visit with a psychiatrist ¹	\$30 copay	\$25 copay
	Virtual behavioral visits	\$0 copay	\$0 copay

Medical benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Skilled nursing facility (SNF) ¹		\$0 copay per day: days 1–20	\$0 copay per day: days 1–20
		\$50 copay per day: days 21–100	\$25 copay per day: days 21–100
		Our plan covers up to 100 days in a SNF per benefit period.	Our plan covers up to 100 days in a SNF per benefit period.
Outpatient Rehabilitation (physical, occupational, or speech/language therapy) ¹		\$25 copay	\$10 copay
Ambulance ²		\$50 copay	\$50 copay
Routine transportation		Not covered	Not covered
Medicare Part B Drugs	Chemotherapy drugs ¹	20% coinsurance	20% coinsurance
	Other Part B drugs ¹	20% coinsurance	20% coinsurance
Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.			

Drug payment stages

The dollar amount you pay for each prescription filled can vary, depending on the coverage stage you're in. You may pay a **copay**, or fixed amount, for some covered drugs and **coinsurance**, which is a percentage of the total cost, for other covered drugs.

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.

	Standard plan	Premium plan
Tier drug coverage (After you pay your deductible, if applicable)	Retail Cost-Sharing 31-day supply	Retail Cost-Sharing 31-day supply
Tier 1: Preferred Generic	\$0 copay for select generics** \$15 copay for all other generics	\$0 copay for select generics** \$15 copay for all other generics
Tier 2: Preferred Brand ¹	\$45 copay	\$45 copay
Tier 3: Non-Preferred Drug ¹	\$85 copay	\$85 copay
Tier 4: Specialty Tier ¹	\$85 copay	\$85 copay
Tier drug coverage (After you pay your deductible, if applicable)	Mail Order or Retail Cost-Sharing 100-day supply	Mail Order or Retail Cost-Sharing 100-day supply
Tier 1: Preferred Generic	\$0 copay for select generics** \$37.50 copay for all other generics	\$0 copay for select generics** \$37.50 copay for all other generics
Tier 2: Preferred Brand ¹	\$112.50 copay	\$112.50 copay
Tier 3: Non-Preferred Drug ¹	\$212.50 copay	\$212.50 copay
Tier 4: Specialty Tier ¹	\$212.50 copay	\$212.50 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.	

¹You 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.

** Please see the Additional Drug Coverage list for more information on generic drugs with a \$0 copay.

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.

SHBP 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/shbp 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		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Acupuncture services	Medicare-covered acupuncture (for chronic low back pain)	\$18 copay	\$18 copay
	Chiropractic services	\$18 copay	\$18 copay
Chiropractic services	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) ¹	\$18 copay	\$18 copay
	Routine chiropractic services	\$30 copay, up to 20 visits per plan year*	\$25 copay, up to 20 visits per plan year*

Additional benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
 Diabetes management	Diabetes monitoring supplies ¹	<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>	<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 ¹	\$0 copay	\$0 copay
	Diabetes self-management training	\$0 copay	\$0 copay
	Therapeutic shoes or inserts ¹	20% coinsurance	20% coinsurance

Additional benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Diabetes Prevention and Weight Management Program		<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 uhc.realappeal.com</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>	<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 uhc.realappeal.com</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>
Durable medical equipment (DME) and related supplies	Durable medical equipment (e.g., wheelchairs, oxygen) ¹	20% coinsurance	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs) ¹	20% coinsurance	20% coinsurance
 Fitness program SilverSneakers®		<p>\$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.</p> <p>Call or go online to learn more and to get your SilverSneakers ID number. 1-888-338-1722, TTY 711 or SilverSneakers.com/StartHere.</p>	<p>\$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.</p> <p>Call or go online to learn more and to get your SilverSneakers ID number. 1-888-338-1722, TTY 711 or SilverSneakers.com/StartHere.</p>

Additional benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
Foot care (podiatry services)	Foot exams and treatment ¹	\$30 copay	\$25 copay
	Routine foot care	\$25 copay, 6 visits per plan year*	\$15 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: <ul style="list-style-type: none"> • 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.	\$0 copay for the following benefits for up to 30 days following each inpatient hospital and SNF stay: <ul style="list-style-type: none"> • 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.
 Home health care¹		\$0 copay	\$0 copay

Additional benefits		Standard plan In-network and out-of-network	Premium plan In-network and out-of-network
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.	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 services¹		\$0 copay	\$0 copay
Outpatient substance use disorder services	Outpatient group therapy visit ¹	\$30 copay	\$25 copay
	Outpatient individual therapy visit ¹	\$30 copay	\$25 copay
Renal dialysis¹		20% coinsurance	20% coinsurance

¹Some 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.

²Authorization is required for non-emergency Medicare-covered ambulance air transportation. Authorization is not required for non-emergency Medicare-covered ambulance ground. 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 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 the SHBP.

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

If you are not entitled to Medicare Part A, please refer to SHBP's enrollment materials, or contact SHBP directly to determine if you are eligible to enroll in our plan. Some plan sponsors have made arrangements with us to purchase Medicare Part A on your behalf.

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/shbp 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 and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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

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

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

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

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se 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. 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.

Always talk with your doctor before starting an exercise program.

1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.
2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

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