



# Summary of Benefits 2026

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

Group Name (Plan Sponsor): City of Livermore

Group Number: 15484

H2001-837-000

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



**Toll-free 1-866-226-8089, TTY 711**

8 a.m.-8 p.m. local time, 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 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	
<b>Monthly plan premium</b>	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.	
<b>Maximum out-of-pocket amount</b> (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	
<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
Cost sharing for additional plan	Outpatient surgery	\$0 copay

## Medical benefits

		In-network and out-of-network
covered services will apply.	Outpatient hospital services, including observation	\$0 copay
 <b>Doctor visits</b>	Primary care provider (PCP)	\$5 copay
	Virtual visit	\$0 copay for designated providers \$5 copay for other providers
	Specialist <sup>1</sup>	\$5 copay
<b>Preventive services</b>	Routine physical	\$0 copay; 1 per plan year*
	Medicare-covered	\$0 copay
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal aortic aneurysm screening</li> <li><input type="checkbox"/> Alcohol misuse counseling</li> <li><input type="checkbox"/> Annual wellness visit</li> <li><input type="checkbox"/> Bone mass measurement</li> <li><input type="checkbox"/> Breast cancer screening (mammogram)</li> <li><input type="checkbox"/> Cardiovascular disease (behavioral therapy)</li> <li><input type="checkbox"/> Cardiovascular screening</li> <li><input type="checkbox"/> Cervical and vaginal cancer screening</li> <li><input type="checkbox"/> Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)</li> <li><input type="checkbox"/> Depression screening</li> <li><input type="checkbox"/> Diabetes screenings and monitoring</li> <li><input type="checkbox"/> Diabetes – Self-Management training</li> <li><input type="checkbox"/> Dialysis training</li> <li><input type="checkbox"/> Glaucoma screening</li> <li><input type="checkbox"/> Hepatitis C screening</li> <li><input type="checkbox"/> HIV screening</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney disease education</li> <li><input type="checkbox"/> Lung cancer with low dose computed tomography (LDCT) screening</li> <li><input type="checkbox"/> Medical nutrition therapy services</li> <li><input type="checkbox"/> Medicare Diabetes Prevention Program (MDPP)</li> <li><input type="checkbox"/> Obesity screenings and counseling</li> <li><input type="checkbox"/> Prostate cancer screenings (PSA)</li> <li><input type="checkbox"/> Sexually transmitted infections screenings and counseling</li> <li><input type="checkbox"/> Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li><input type="checkbox"/> Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19</li> <li><input type="checkbox"/> “Welcome to Medicare” preventive visit (one-time)</li> </ul>

## 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

\$20 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

\$20 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)<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

#### Hearing services



Exam to diagnose and treat hearing and balance issues<sup>1</sup>

\$5 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.
 <b>Routine dental services</b> See Evidence of Coverage for more details.	Oral exams	\$0 copay, 2 procedures per plan year.
	Routine cleaning	\$0 copay, 2 procedures per plan year.
	Dental bitewing X-rays	\$0 copay, 1 procedure per plan year.
	Benefit limit	\$0 yearly deductible and \$0 combined in and out-of-network plan year maximum. If you receive services from an out-of-network dentist, the plan pays according to a maximum allowable fee schedule. You pay all fees in excess of this amount.
 <b>Vision services</b>	Exam to diagnose and treat diseases and conditions of the eye <sup>1</sup>	\$5 copay
	Eyewear after cataract surgery	\$0 copay
	Routine eye exam	\$0 copay, 1 exam every 12 months*
	Routine eyewear	Plan pays up to \$70 for eyeglasses, or up to \$105 for contact lenses instead of eyeglasses, every 24 months.*

Medical benefits		
		In-network and out-of-network
<b>Mental health</b>	Inpatient visit <sup>1</sup>	\$0 copay per stay, up to 190 days  Our plan covers 190 days for an inpatient hospital stay.
	Outpatient group therapy visit <sup>1</sup>	\$5 copay
	Outpatient individual therapy visit <sup>1</sup>	\$5 copay
	Outpatient therapy or office visit with a psychiatrist <sup>1</sup>	\$5 copay
	Virtual behavioral visits	\$5 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
<b>Routine transportation</b>		Not covered
<b>Medicare Part B Drugs</b>	Chemotherapy drugs <sup>1</sup>	\$0 copay
	Other Part B drugs <sup>1</sup>	\$0 copay
Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.		

<b>Prescription drugs</b>		
<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 ~	\$15 copay	\$30 copay
<b>Tier 3:</b> Non-Preferred Drug ~	\$35 copay	\$70 copay
<b>Tier 4:</b> Specialty Tier ~	25% coinsurance (limited to a 30-day supply)	25% coinsurance (limited to a 30-day supply)
<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.  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. 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](http://retiree.uhc.com) 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



### **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**

		<b>In-network and out-of-network</b>
<b>Acupuncture services</b>	Medicare-covered acupuncture (for chronic low back pain)	\$5 copay
	Routine acupuncture services	\$5 copay, up to 20 visits per plan year*
<b>Chiropractic services</b>	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation) <sup>1</sup>	\$5 copay

## Additional benefits

	In-network and out-of-network	
	Routine chiropractic services	\$5 copay, up to 20 visits per plan year*
 <b>Diabetes management</b>	Diabetes monitoring supplies <sup>1</sup>	\$0 copay  We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan.  Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide.  Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.
	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

## Additional benefits

		In-network and out-of-network
	<b>Fitness program</b> 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 <a href="https://www.silversneakers.com/StartHere">SilverSneakers.com/StartHere</a>.</p>
<b>Foot care (podiatry services)</b>	Foot exams and treatment <sup>1</sup>	\$5 copay
	Routine foot care	\$5 copay, 12 visits per plan year*
	<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
<b>Outpatient substance use disorder services</b>	Outpatient group therapy visit <sup>1</sup>	\$5 copay
	Outpatient individual therapy visit <sup>1</sup>	\$5 copay

## Additional benefits

### In-network and out-of-network

**Renal dialysis<sup>1</sup>**

\$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](https://retiree.uhc.com) 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 member ID card or the front of your plan booklet.

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

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

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

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

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

You must continue to pay your Medicare Part B premium.

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

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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