

2020 Plan Summary

Plan N

UnitedHealthcare® Senior Supplement®

Underwritten by UnitedHealthcare Insurance Company

In New York, Underwritten by UnitedHealthcare Insurance Company of New York

All covered amounts will vary depending on Medicare benefits for any particular year. Amounts listed on this summary are for Year 2020 benefits. Amounts may change for the Year 2021.

This summary is intended only to show highlights of benefits and should not be relied upon to fully determine health care expenses. Once you are enrolled in the plan, you will receive a Welcome Kit which will include a Certificate and Schedule of Benefits. These documents will provide you with a listing of services, limitations, exclusions, and a description of the terms, conditions of coverage and any state mandated benefits. If this description conflicts in any way with the policy issued to the enrolling group, the policy prevails.

If you would like to receive the Certificate and Schedule of Benefits before you enroll in the plan, please call Customer Service at the number located on the back of this booklet. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Covered Service	Medicare Pays	Senior Supplement Pays	You Pay
Emergency and Urgent Care Services			
If not admitted, Medicare Part B Deductible applies			
Per visit	80%	20% after copayment per visit	\$50 copayment (waived if admitted)
Inpatient Hospital Services			
Medicare Part A Hospital – semi-private room and board, general nursing and miscellaneous services and supplies.			
Days 1 – 60	All but \$1,408	\$1,408 (Medicare Part A Deductible)	\$0
Days 61 – 90	All but \$352 per day	\$352 per day	\$0
Days 91 – 150 (While using 60 lifetime reserve days)	All but \$704 per day	\$704 per day	\$0
Days 151 – 365 – lifetime additional reserve days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond 365 lifetime additional reserve days	\$0	\$0	All costs

Covered Service	Medicare Pays	Senior Supplement Pays	You Pay
Skilled Nursing Facility Care			
You must meet Medicare's requirements, including having been in a Hospital for at least 3 days and entering the Medicare approved facility within 30 days of leaving the Hospital.			
Days 1 – 20	All approved amounts	\$0	\$0
Days 21 – 100	All but \$176 per day	Up to \$176 per day	\$0
Days 101 and after	\$0	\$0	All costs
Blood			
First 3 pints Medicare Part A	\$0	100%	\$0
Additional amounts under Medicare Part A	100%	\$0	\$0
First 3 pints Medicare Part B	\$0	100%	\$0
Next \$198 of Medicare Approved Amounts under Medicare Part B	\$0	\$0	\$198 (Medicare Part B Deductible) ¹
Remainder of Medicare Approved Amounts under Medicare Part B	80%	20%	\$0
Hospice Services			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	100% of Balance	\$0
Medical Services			
Includes services such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy and diagnostic tests.			
First \$198 of Medicare Approved Amounts	\$0	\$0	\$198 (Medicare Part B Deductible) ¹
Physician Office Visit	\$0	\$0	\$20 copayment per office visit
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Outpatient Mental Illness – for most outpatient mental illness services	80%	20% after copayment	\$20 copayment per visit
Medicare Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs

Covered Service	Medicare Pays	Senior Supplement Pays	You Pay
Preventive Healthcare (Medicare Covered)			
Periodic Health Screenings (please refer to your certificate)	100%	Balance (if applicable)	\$0
Durable Medical Equipment			
First \$198 of Medicare Approved Amounts	\$0	\$0	\$198 (Medicare Part B Deductible) ¹
Remainder of Medicare Approved Amounts	80% of approved amounts	20% of approved amounts	\$0
Home Health Care			
Skilled Care Services and Medical Supplies	All approved amounts	Balance (if applicable)	\$0
Preventive Healthcare (not covered by Medicare)			
Annual Routine Physical Exam	\$0	100%	\$0
Foreign Travel			
Medically Necessary Emergency Care services beginning during the first six months of each trip outside the United States. First \$250 each calendar year	\$0	\$0	\$250 Deductible
Remainder of charges	\$0	80% up to a lifetime maximum benefit of \$50,000	20% and all amounts over the \$50,000 lifetime maximum

Exclusions and Limitations

No benefits will be provided for, or in connection with, the following treatments, services or supplies:

- Any expense or service that is not determined by the Company to be a Medicare Eligible Expense, unless coverage for the expense or service is specifically provided by a Rider to the Policy.
- Any treatment, service or supply paid for by Medicare or found to be medically unnecessary or unnecessary by Medicare.
- Any treatment, service or supply that is provided before the effective date of coverage or after coverage has terminated.
- Any injury or sickness due to any past or present employment, or that is covered under any Workers' Compensation law or similar law.
- Charges for self-inflicted injury or attempted suicide.
- Any treatment, confinement, services or supply provided by a government owned or operated facility.
- Any injury or sickness resulting from war or any act of war (declared or undeclared).
- Acts beyond the company's control such as any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, which result in the unavailability of the facilities or personnel.
- Charges incurred as a result of participation in a riot, insurrection or the commission of a felony.
- Blood and plasma except as stated above.
- Experimental or investigational treatment, procedures and items.
- Medicare Part B Deductible.
- Hospital expenses for days 366 and beyond after the Medicare 60 lifetime reserve days have been used.
- Medicare Part B Excess Charges.

This Plan Summary is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, or Exclusions and Limitations.

Visit us online anytime

Learn more at
www.UHCRetiree.com

Toll-free **1-800-698-0822**, TTY **711**
8 a.m. – 8 p.m. local time, 7 days a week

¹Once \$198 of Medicare Approved Amounts for covered services have been paid, the Medicare Part B Deductible will have been met for the calendar year.