Schedule of BENEFITS

UnitedHealthcare® Senior Supplement®

Underwritten by UnitedHealthcare Insurance Company

Plan N

The Schedule of Benefits is a summary of any Deductibles, Coinsurance and other limits when You receive Covered Services and, with the Certificate, describes your coverage under the Policy. Please refer to **Section One: Your Medical Benefits** in Your Certificate for a more complete explanation of the specific services covered by the Policy. All Covered Services are subject to any Deductible, Coinsurance, conditions, exclusions, limitations, terms and provisions of the Certificate, including any attachment or riders.

The benefits described in the Certificate are based on the assumption that Covered Persons are enrolled in Medicare Part A and Part B. For any Covered Expense that is a Medicare Eligible Expense, the amount payable by the company will be based upon that portion of the Covered Expenses that Medicare does not pay under Medicare Part A and Part B, subject to the conditions, exclusions, limitations, terms and provisions of the Certificate, including any attachments or riders. Covered Persons must use Medicare participating Providers, approved Facilities and approved Hospice agencies.

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Emergency and Urgent Care Services Copayment (per visit)	Plan Pays	You Pay
Emergency Services	$0	$50 Copayment per visit (waived if admitted)
After satisfaction of the Copayment, benefits will be paid the same as for All Other Inpatient Benefits.	Copayments are the responsibility of the Covered Person	
Inpatient Benefits		
Medicare Part A Deductible	100% of Part A Deductible	0%
Days 1-60 of Inpatient Hospital Services		
Inpatient Hospital Services		
Days 61-90	100% Coinsurance	$0
Days 91-150 (While using 60 lifetime reserve days)	100% Coinsurance	$0
Days 151-365 (lifetime additional reserve days)	100% Coinsurance	$0
Beyond 365 (lifetime additional reserve days)	Not Covered	Balance
Inpatient Mental Health	Same as Inpatient Hospital above	Balance
Skilled Nursing Facility (SNF)		
Days 1–20 Covered by Medicare	$0	$0
Days 21–100	100% Coinsurance	$0
Days 101–365	Not Covered	Balance
Beyond 365 Days	Not Covered	Balance
SNF — prior hospital stay requirement is not waived		

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Blood and Blood Products	Plan Pays	You Pay
Blood (First three pints are covered)	100% Coinsurance	$0
Hospice Services	100% Coinsurance	$0
Respite Care	100% Coinsurance	$0
Inpatient Physician Services (including specialists and other licensed health care professionals)	100% Coinsurance	$0
All Other Inpatient Services Billed by Hospital or Facility	100% Coinsurance	$0
Outpatient & Part B Benefits		
Medicare Part B Deductible	0%	100%
Medicare Part B Excess Charges	0% Coinsurance	100% Coinsurance
Ambulance	100% Coinsurance	$0
Outpatient Physician Services (Office Visits)	100% Coinsurance after Copayment	$20 Copayment per office visit
Outpatient Physician Services for Specialists (Office Visits)	100% Coinsurance after Copayment	$20 Copayment per office visit

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Outpatient Physician Services (Outpatient Surgery)	Plan Pays	You Pay
(including specialists and other licensed health care professionals)	100% Coinsurance	$0
Outpatient Surgery (Facilities)	100% Coinsurance	$0
Blood and Blood Products Blood (First three pints are covered)	100% Coinsurance	$0
Infusion Therapy	100% Coinsurance	$0
Periodic Health Screenings (Preventive Care) - Please Refer to Your Certificate	100% Coinsurance	$0
Pap Smears (for annual routine exams not covered by Medicare)	100% Coinsurance	$0
Outpatient Mental Health Care	100% Coinsurance after Copayment	$20 Copayment per visit
Alcohol, Drug or other Substance Abuse	100% Coinsurance	$20 Copayment per visit
Outpatient Injectables (Medicare Part B Drugs Only)	100% Coinsurance	$0

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Outpatient Prescription Drugs Covered by Medicare (Medicare Part B Drugs Only)	**Plan Pays**	**You Pay**
Oral Chemo Anti-Emetics Antigens	100% Coinsurance	$0
Durable Medical Equipment (when covered by Medicare)	100% Coinsurance	$0
Home Health Care (for expenses covered by Medicare)	100% Coinsurance	$0
All Other Outpatient Benefits	100% Coinsurance	$0
Additional Benefits		
Annual Routine Physical Exam (not covered by Medicare)	100% Coinsurance	$0
Other Services		
Foreign Travel Benefit	$0 Deductible	$250 Deductible per Calendar Year
	80% Coinsurance up to a maximum benefit of $50,000 per lifetime	Balance

THIS POLICY HAS CERTAIN BENEFIT MAXIMUMS. PLEASE REVIEW THIS INFORMATION CAREFULLY SO YOU WILL UNDERSTAND YOUR BENEFITS UNDER THIS PLAN.

NOTE: For Covered Services which are not Medicare Eligible Expenses, Covered Expenses will be paid in accordance with the Usual and Customary Charge criteria as defined in the Certificate.

Notes

Notes

Toll-Free **1-800-851-3802**, TTY **711**
8 a.m. – 8 p.m. local time, Monday – Friday

www.UHCRetiree.com
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