Schedule of Benefits

UnitedHealthcare® Senior Supplement®
Underwritten by UnitedHealthcare Insurance Company

Plan F

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

retiree.uhc.com

United Healthcare

SRINS-SOB-CA-1

Schedule of Benefits

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.

	Plan pays	You pay
Inpatient benefits		
Medicare Part A deductible Days 1–60 of inpatient hospital services	100% of Part A deductible	0%
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		

	Plan pays	You pay
Blood and blood products 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	100% of Part B deductible	0%
Medicare Part B excess charges	100% coinsurance	0% coinsurance
Ambulance	100% coinsurance	$0
Outpatient physician services (office visits)	100% coinsurance	$0
Outpatient physician services for specialists (office visits)	100% coinsurance	$0
Outpatient physician services (outpatient surgery) (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
Diabetic self management items (not covered by Medicare)	100% coinsurance	$0
Immunizations for adults (not covered by Medicare)	100% coinsurance	$0
Infusion therapy	100% coinsurance	$0
Periodic health screenings (preventive care) — please refer to your certificate	100% coinsurance	$0

	Plan pays	You pay
Pap smears (for annual routine exams not covered by Medicare)	100% coinsurance	$0
Outpatient mental health care	100% coinsurance	$0
Alcohol, drug or other substance abuse	100% coinsurance	$0
Outpatient injectables (Medicare Part B drugs only)	100% coinsurance	$0
Outpatient prescription drugs covered by Medicare (Medicare Part B drugs only) Oral chemo Anti-emetics Antigens	100% coinsurance	$0
Specialized footwear (not covered by Medicare)	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
Foreign travel benefit	$0 deductible 80% coinsurance up to a maximum benefit of $50,000 per lifetime	$250 deductible per calendar year 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.