

## CA Schools VEBA: Senior Supplement Plan 2012

All covered amounts will vary depending on Medicare benefits for any particular year. Amounts listed on this summary are for Year 2012 benefits. Amounts may change for the Year 2013.

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
<b>Inpatient Hospital Services</b>			
Medicare Part A Hospital – semi-private room and board, general nursing and miscellaneous services and supplies.			
Days 1 – 60	All but \$1,156	\$1,156 (Medicare Part A Deductible)	\$0
Days 61 – 90	All but \$289 per day	\$289 per day	\$0
Days 91 – 150 (While using 60 lifetime reserve days)	All but \$578 per day	\$578 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
<b>Skilled Nursing Facility Care</b>			
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 \$144.50 per day	Up to \$144.50 per day	\$0
Days 101 and after	\$0	\$0	All costs

Covered Service	Medicare Pays	Senior Supplement Pays	You Pay
<b>Blood</b>			
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 \$140 of Medicare Approved Amounts under Medicare Part B	\$0	\$140 (Medicare Part B Deductible) <sup>1</sup>	\$0
Remainder of Medicare Approved Amounts under Medicare Part B	80%	20%	\$0
<b>Hospice Services</b>			
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
<b>Medical Services</b>			
Includes services such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy and diagnostic tests.			
First \$140 of Medicare Approved Amounts	\$0	\$140 (Medicare Part B Deductible) <sup>1</sup>	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Outpatient Mental Illness – for most outpatient mental illness services	55%	45%	\$0
Medicare Part B Excess Charges (above Medicare Approved Amounts)	\$0	100%	\$0
<b>Preventive Healthcare (Medicare Covered)</b>			
Periodic Health Screenings (please refer to your certificate)	100%	Balance (if applicable)	\$0

Covered Service	Medicare Pays	Senior Supplement Pays	You Pay
<b>Durable Medical Equipment</b>			
First \$140 of Medicare Approved Amounts	\$0	\$140 (Medicare Part B Deductible) <sup>1</sup>	\$0
Remainder of Medicare Approved Amounts	80% of approved amounts	20% of approved amounts	\$0
<b>Home Health Care (Medicare Covered)</b>			
Skilled Care Services and Medical Supplies	All approved amounts	Balance (if applicable)	\$0
<b>At-Home Recovery Services – Not Covered by Medicare</b>			
Home Care certified by the Covered Person's treating physician, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care treatment plan.			
Benefit for each visit	Not covered	\$40 maximum per visit	Balance
Number of visits covered Care must be received while the Covered Person is receiving Medicare Home Care, or within 8 weeks of the termination of the Medicare Home Care. Visits paid by Medicare or other government programs are not covered. Care provided by family members or unpaid volunteers is not covered.	Not covered	Up to the number of Medicare approved visits, not to exceed seven 4-hour visits each week	Balance
Calendar Year Maximum	Not covered	\$1,600	Balance
<b>Foreign Travel</b>			
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.
- Hospital expenses for days 366 and beyond after the Medicare 60 lifetime reserve days have been used.
- Preventive Care (except to the extent charges are approved for coverage under Medicare).

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



Call Customer Service:

**1-800-698-0822, TTY 711**

8 a.m. – 8 p.m. local time, 7 days a week

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<sup>1</sup>Once \$140 of Medicare Approved Amounts for covered services have been paid, the Medicare Part B Deductible will have been met for the calendar year.

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