SUMMARY OF BENEFITS
UnitedHealthcare Medicare plan

Archdiocese of New York
Medicare Supplemental Plan for Religious (MSYRX)

Effective January 1, 2017, if you have any questions please call UnitedHealthcare Member Services at 1-800-736-1264 or register on myuhc.com to get detailed information on your coverage.

Your Medicare Supplemental plan provides a maximum freedom for dealing with any health care situation. This incredibly flexible program lets you make your own health care decisions, including which doctors and specialists to visit. Benefits are provided for covered health services received from any physician or other licensed medical provider. This plan coordinates with Medicare.

Some Important Benefits of your plan:

- Receive care from any licensed medical physician or other provider you want.
- Choose to see any licensed specialist you want without having to get a referral.
- Go to any hospital you want-anywhere, anytime.
- Emergencies are covered anywhere in the world.
- Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery, when covered health services are provided.
- We offer the Language Line Services so that you can talk with us in 140 different languages. Just call customer service and ask for an interpreter.
- Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.
- The tools and information at myuhc.com are practical and personalized so you can get the most out of your benefits. Register at myuhc.com and connect to current information about your benefits and health care interests.
- Cancer Resource Services provides information on comprehensive cancer treatment services. Benefit from using one of our Centers of Excellence by calling 1-866-936-6002.
Medicare Supplemental Plan Benefits Summary

Types of Coverage
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan.

If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail.

Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.

<table>
<thead>
<tr>
<th>Benefits /Copayment Amounts</th>
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<tbody>
<tr>
<td><strong>Annual Deductible:</strong> $150 per Covered Person per calendar year.</td>
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<tr>
<td><strong>Out-of-Pocket Maximum:</strong> $750 per Covered Person per calendar year.</td>
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<td><strong>Maximum Plan Benefit:</strong> No Maximum Plan Benefit.</td>
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**MEMBER PAYS**

1. **Ambulance Services - Emergency only**
   - Ground Transportation: 0% of Eligible Expenses
   - Air Transportation: 0% of Eligible Expenses

2. **Dental Services - Accident only** – Treatment must begin within six months of injury.
   - 20% of Eligible Expenses after satisfying deductible

3. **Durable Medical Equipment**
   - The purchase or rental of prescribed equipment is covered including needed replacement and repair.
   - 20% of Eligible Expenses after satisfying deductible

4. **Emergency Health Services**
   - 0% of Eligible Expenses

5. **Refractive Eye Examinations**
   - No Coverage

6. **Home Health Care**
   - Benefits are limited to 200 visits for skilled care services per calendar year.
   - 20% of Eligible Expenses after satisfying deductible

7. **Hospice Care**
   - No annual maximum
   - 20% of Eligible Expenses after satisfying deductible

8. **Hospital - Inpatient Stay**
   - 0% of Eligible Expenses

9. **Injections Received in a Physician’s Office**
   - 20% of Eligible Expenses after satisfying deductible

10. **Maternity Services**
    - No coverage

11. **Outpatient Surgery, Diagnostic and Therapeutic Services**
    - Outpatient Surgery
      - 20% of Eligible Expenses after satisfying deductible
    - Outpatient Diagnostic Services
      - For lab and radiology/Xray: 20% of Eligible Expenses after satisfying deductible
      - For mammography testing: 20% of Eligible Expenses after satisfying deductible
    - Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine
      - 20% of Eligible Expenses after satisfying deductible
    - Outpatient Therapeutic Treatments
      - 20% of Eligible Expenses after satisfying deductible

12. **Physician’s Office Services**
    - 20% of Eligible Expenses after satisfying deductible

13. **Professional Fees for Surgical and Medical Services**
    - 20% of Eligible Expenses after satisfying deductible

14. **Prosthetic Devices**
    - The purchase or rental of prescribed equipment is covered including needed replacement and repair.
    - 20% of Eligible Expenses after satisfying deductible

15. **Reconstructive Procedures**
    - Hospital Inpatient Stay – 20% of Eligible Expenses after satisfying deductible.
    - Outpatient Surgery - 20% of Eligible Expenses after satisfying deductible.
    - Outpatient Diagnostic Therapeutic Services – 20% of Eligible Expenses after satisfying deductible.
    - Outpatient Therapeutic Treatments - 20% of Eligible Expenses after satisfying deductible.
    - Physician’s Office Services - 20% of Eligible Expenses after satisfying deductible.
### Types of Coverage

**16. Rehabilitation Services - Outpatient Therapy**
- 90 visits per year for all types of therapy combined (physical therapy, occupational therapy, cardiac rehabilitation, restorative speech therapy, and chiropractic care).
- **Benefits / Copayment Amounts**
  - 20% of Eligible Expenses after satisfying deductible

**17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**
- Benefits are limited to 120 days per calendar year.
- **Benefits / Copayment Amounts**
  - 0% of Eligible Expenses after satisfying deductible

**18. Transplantation Services**
- **Benefits / Copayment Amounts**
  - 20% of Eligible Expenses after satisfying deductible

**19. Urgent Care Center Services**
- **Benefits / Copayment Amounts**
  - 0% of Eligible expenses

### Additional Benefits

**Mental Health Services – Outpatient**
- **Benefits / Copayment Amounts**
  - 20% of Eligible Expenses after satisfying deductible

**Mental Health Services - Inpatient and Intermediate**
- 0% of Eligible Expenses

**Substance Abuse Services – Outpatient**
- **Benefits / Copayment Amounts**
  - 20% of Eligible Expenses after satisfying deductible

**Substance Services - Inpatient and Intermediate**
- 0% of Eligible Expenses

### Prescription Drugs - Rx vendor is CVSHealth/Caremark (1-800-565-7091)

- **Retail Drug Program** –
  - $5 per 30-day supply for generic drugs
  - $20 per 30-day supply for preferred drugs
  - $35 per 30-day supply for non-preferred drugs

- **Mail Order Program** –
  - $10 per 90-day supply for generic drugs
  - $40 per 90-day supply for preferred drugs
  - $70 per 90-day supply for non-preferred drugs

- Pharmacy fills: On the third fill of a maintenance drug at the retail pharmacy, the copay changes to $10/40/70 per 30 day supply.

- Generic Incentive: When you fill a Rx for a brand name drug that has a generic equivalent you pay the brand name copay plus the difference in the cost between the brand name and its generic equivalent.
This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.