2021 Individual & Family Plan

UCare Silver Member Contract

ucare®

Important Contact Information

Customer Service
612-676-6600 or 1-877-903-0070 toll free

TTY/Hearing Impaired: 612-676-6810 or 1-800-688-2534 toll free

Hours: 8 am – 6 pm, Monday – Friday
Customer Service offers free language interpreter services for non-English speakers.

Mental Health and Substance Use Disorder Services
For questions about mental health or substance use disorder services call:
612-676-6533 or toll free 1-833-276-1185

Mailing Address
UCare
PO Box 52
Minneapolis, MN 55440-0052

Street Address
500 Stinson Blvd. NE
Minneapolis, MN 55440-0052

Website
ucare.org

UCare 24/7 Nurse Line
For reliable health information 24 hours a day, seven days a week, call the UCare 24/7 nurse line. The nurses will offer advice when you're not feeling well and answer your health questions. They can also advise about whether you should go to an urgent care center or the emergency room (ER). This service costs you nothing. Call the phone number on your member ID card.

Renewal

You may keep your current plan or change coverage for next year during the annual open enrollment period. You may be eligible for special enrollment periods under certain situations. See the *Changing Your Coverage* section to learn more.

This health plan may not cover all your health care expenses. Read this Contract carefully to learn which expenses are covered.

Right to Cancel

You may cancel this Contract within 10 days of receiving it by delivering this Contract and a written notice to UCare, 500 Stinson Blvd. NE, Attn: Customer Service, Minneapolis, MN 55440-0052. Or mail a written notice to UCare, PO Box 52, Minneapolis, MN 55440-0052. This Contract must be returned before midnight of the 10th day after the date you received it. The Contract will then be void from the beginning. You must pay any claims incurred before it was cancelled. UCare will return all premium payments made for this Contract within 10 days after receipt of notice of cancellation and the returned Contract.

If You Want to Leave this Plan – Contact MNsure

If you choose to leave this plan, you must contact MNsure at least one month before you want your coverage to end. Your request can be verbal or in writing. MNsure's phone number is 651-539-2099 or 1-855-366-7873.

Reasons why you may want to end your coverage include, but are not limited to:

- You are enrolling in Medicare or a UCare Medicare Advantage plan
- You obtained health insurance through an employer
- You recently got married and have coverage through your spouse
- You are eligible for Medical Assistance

See the *Ending Coverage* section to learn more.

Notice of Nondiscrimination

UCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UCare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the number on the back of your membership card or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance

Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတၢ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ័ខ្មរ, រសរាជំនួយរ័ផ្នកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم والبكم: 612-676-6810/1-800-688-2534).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

Dear UCare Member,

Welcome to UCare, where members come first. We're pleased you chose us.

We have offered high-quality, affordable health coverage to Minnesotans for three decades. We bring special value to our members and communities by living our mission of improving members' health through innovative services and community partnerships. Our goal is to help Minnesotans of all ages, abilities and cultures access care.

Disclosure Required By Minnesota Law

This Contract is expected to return on average 84.6% of your coverage costs for health care. The lowest percentage permitted by state law for this Contract is 72%.

Please Read Your Contract Carefully

This Contract, together with any amendments we may send you, is your evidence of coverage and is issued by UCare Minnesota (UCare). It is our legal Contract with you and describes your benefits and coverage. This Contract replaces your prior Contract with UCare, if any.

IN WITNESS WHEREOF, UCare's President and Secretary hereby sign your Contract.

Mark Traynor
President and
Chief Executive Officer

Hilary Marden-Resnik
Senior Vice President,
Chief Administration Officer
and Secretary of the Board

Important Member Information & Member Rights and Responsibilities

MEMBER INFORMATION

1. COVERED SERVICES: Services provided by UCare will be covered at the in-network benefit level when services are provided by participating UCare providers or as authorized by UCare. Your Contract fully defines what services are covered and describes procedures you must follow to obtain coverage.
2. PROVIDERS: Enrolling in UCare does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of UCare's network for this plan, you must choose among remaining UCare providers to receive services at the in-network benefit level.
3. EMERGENCY SERVICES: Emergency services from providers who are not affiliated with UCare will be covered. Your Contract explains the procedures and benefits associated with emergency care from UCare in-network providers and non-network providers.
4. EXCLUSIONS: Certain services or medical supplies are not covered. You should read the Contract for a detailed explanation of all exclusions.
5. CANCELLATION: Your coverage may be canceled by you or UCare only under certain conditions. Your Contract describes all reasons for cancellation of coverage.

6. NEWBORN COVERAGE: If your health plan provides for dependent coverage, a newborn infant can be covered from birth. UCare will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify MNsure and UCare of the infant's birth and that you would like coverage. If your Contract requires an additional premium for each dependent, UCare is entitled to all premiums due from the time of the infant's birth until the time you notify MNsure and UCare of the birth. UCare may withhold payment of any health benefits for the newborn infant until any premiums you owe are paid.
7. PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT: Enrolling in UCare does not guarantee that any particular prescription drug will be available or that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Contract year.

MEMBER RIGHTS AND RESPONSIBILITIES

As a UCare member of this plan, you have the right to:

1. Available and accessible services including emergency services, as defined in your Contract, 24 hours a day, seven days a week;
2. Be informed of health problems, and to receive information regarding medically necessary treatment options and risks that are sufficient to assure informed choice, regardless of cost or benefit coverage;
3. Refuse treatment, and the right to privacy of medical and financial records maintained by UCare and its health care providers, in accordance with existing law;
4. Make a complaint or appeal a coverage decision, and the right to initiate a legal proceeding when experiencing a problem with UCare or its health care providers. (See the *Appeals and Complaints* section for more information on your rights);
5. Receive information about UCare, its services, its practitioners and providers, and your rights and responsibilities;
6. Be treated with respect and recognition of your dignity and your right to privacy;
7. Participate with your providers in making health care decisions; and
8. Make recommendations regarding the organization's member rights and responsibilities policy.

As a UCare member of this plan, you have the responsibility to:

1. Supply information (to the extent possible) that the organization and its providers need in order to provide care;
2. Follow plans and instructions for care that you have agreed to with your providers to sustain and manage your health;
3. Understand your health needs and problems, and participate in developing mutually agreed-upon treatment goals to the degree possible; and
4. Pay copayments at the time of service and to promptly pay deductibles, coinsurance and, if applicable, additional charges for non-covered services.

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Introduction

This Contract is the evidence of coverage for the plan issued by UCare and UCare Health, Inc. It is approved by the State of Minnesota. This plan is certified as a Qualified Health Plan (QHP) and is offered through MNsure. This plan is subject to state and federal laws and regulations.

UCare Minnesota (UCare) is a nonprofit corporation licensed by the State of Minnesota as a Health Maintenance Organization (HMO). UCare underwrites and administers the covered services provided by an in-network provider as described in this Contract. UCare is the parent company of UCare Health, Inc. to which UCare provides administrative services. When used in this Contract, "we," "us" or "our" have the same meaning as UCare and UCare Health, Inc.

UCare Health, Inc. is the nonprofit service insurance corporation underwriting the covered services provided by a non-network provider as described in this Contract. UCare Health, Inc. is a subsidiary of UCare.

The HMO coverage described in this Contract may not cover all of your health care expenses. Read this Contract carefully to learn which expenses are covered.

The laws of the State of Minnesota provide members of an HMO certain legal rights, including rights described in this Contract.

This Contract covers the enrollee and the enrolled dependents (if any) as named on the enrollee's membership application. The enrollee and his or her enrolled dependents are our members. In this Contract, the words "you," "your" and "yourself " refer to the member.

This Contract describes health services that are eligible for coverage and the steps you must follow to obtain benefits. This Contract contains important information, so read this entire Contract carefully. If you have questions or need more information, call UCare Customer Service at the phone number on the inside cover of this Contract or the back of your member ID card.

Many words in this Contract have specific meaning and are defined in the *Definitions* section at the end of this Contract. Examples include the words "benefits," "claim," "medically necessary," "member," "network," "premium" and "provider."

UCare may arrange for other persons or organizations to provide administrative services on its behalf. This may include claims processing and utilization management services. To ensure efficient administration of your benefits, you must cooperate with them as they perform their duties.

You must follow all terms and conditions of this Contract. All covered health services must be medically necessary.

While a member of our plan, you must use your current member ID card when you receive covered services, including prescription drugs at in-network pharmacies. If you do not show your member ID card, you may have to pay more.

For some services, your provider must request authorization (approval) from us before you receive those services. Information on which services may require approval is in the *Benefits Chart* section of this Contract. More details about these processes are in the *Authorization and Notification* section of this Contract.

Nondiscrimination Policy

UCare treats all persons alike, without bias based on race, color, creed, religion, national origin, gender, marital status, disability, sexual orientation, age, genetic information, public assistance status or any other class protected by law.

Members have equal cost-sharing for covered services without discrimination on the basis of sex, including gender identity. Services that are ordinarily or exclusively available to members of one sex will not be denied to a transgender person based on the sex assigned at birth, gender identity, or if the gender otherwise recorded is different from one to which coverage is ordinarily and exclusively available.

Using Your Benefits

The services covered under this Contract are in the *Benefits Chart* section of this Contract. The *Benefits Chart* also identifies some non-covered items. A list of general and service-specific exclusions not covered by this Contract is in the *Exclusions* section. See those sections to identify covered and non-covered services. Information about our medical policies is available upon request.

Each Time You Get Covered Services

Make sure that your provider is an in-network provider to receive in-network benefit coverage. Even if your in-network provider refers you to another provider, location or facility, check to see if they are in your plan's network. If they are not, you will likely pay more. Identify yourself as a UCare member. Show your current member ID card.

Member Identification (ID) Card

As a member of our plan, you should show your current member ID card every time you receive covered services, including prescription drugs. If you do not show your ID card, you may have to pay more.

We will send you a member ID card when we receive your payment for the first month's premium. If any information on your ID card is wrong or if you lose your card, contact Customer Service right away.

Using Your Plan's Network

Important: This health plan has a provider network. This network may be different from other UCare provider networks. Know your plan's provider network and use in-network providers to get the highest level of benefit coverage.

In-Network Providers

In-network providers are the doctors, other health care professionals, medical groups, hospitals, other facilities and pharmacies that have a contract with UCare to deliver covered health care services to members of this plan. **To get the highest level of benefits for covered services, you should receive services from an in-network provider.** Some services obtained from non-network providers will receive in-network benefits. See the *Non-Network Providers* section to learn more.

There are several ways to find current information about in-network providers and their professional qualifications. This includes medical school attended, residency completed and board certification status.

Search the Network

Visit **ucare.org/searchnetwork** to use the *Search Network* tool. This online listing is updated daily. It lets you search by many criteria, including location. Be sure to select Individual and Family Plans as the health plan to identify in-network providers for this plan.

If you receive services from an in-network provider who becomes a non-network provider before the change is posted in the *Search Network* tool, we must reprocess the claim as an in-network provider. If UCare told you that the provider changed from in-network to non-network in the *Search Network* tool before you obtained services, we will process the claim as a non-network provider.

Call us

Call Customer Service for help finding a provider in your network. The number is inside the front cover of this Contract and on your member ID card.

Check with all of your providers about their in-network status

Your primary care provider may deliver, set up or help you get health care services. To contact your primary care provider, go online to their website or call the clinic. UCare Customer Service may be able to help you schedule appointments.

You do not need a referral to see a specialist, such as mental health or cardiology, if they are an in-network provider.

Your provider will usually set up your hospital admission and care if needed. If you do not know

which hospital your provider is associated with, ask your provider or clinic. If you prefer a specific hospital, see our list of network hospitals in the *Provider Directory* or in the *Search Network* tool at **ucare.org/searchnetwork**.

If you need emergency care, you don't have to go to an in-network provider or facility. However, you are responsible for paying any charges from a non-network provider that exceed the allowed amount UCare pays that provider. For more information on coverage for emergency services, see the *Emergency Room Services* section of the *Benefits Chart* in this Contract.

Doctors and other providers may perform certain services at non-network hospitals, surgical centers and other facilities. We recommend that you confirm with all of your providers that they are still in the plan's network at the time of service.

Non-Network Providers

This plan covers some services from non-network providers. If you receive services from a non-network provider, you may have to pay more compared to your costs for services from an in-network provider. This is because UCare does not have a contract for a discounted fee with non-network providers. This higher cost-sharing amount can apply to copayments, coinsurance and deductibles. See the *Benefits Chart* for details.

In addition to higher cost-sharing amounts, you may have to pay any charges from the non-network provider that exceed the allowed amount that UCare will pay the provider. This is called balance billing. See the *How UCare Pays Providers* and *Balance Billing* sections to learn more.

State law requires that some services from in-network and non-network providers be covered at the same benefit level. These services include emergency services, testing and treatment of sexually transmitted diseases, testing for HIV/AIDS, services to diagnose infertility and voluntary family planning services. When using a non-network provider, you may still have to pay the provider costs that exceed the allowed amount that UCare pays providers for a given service (balance billing). See the *Benefits Chart* to learn more.

Care Outside the Service Area

If you need care outside the plan's service area and it is not an emergency, find a doctor and get the care you need. UCare's nurse line is open 24 hours a day, seven days a week. Except for emergencies, most services provided outside of the UCare service area or the State of Minnesota are considered non-network services. Non-network benefits apply for these services. In some cases, UCare requires advance approvals and notifications. Services outside of the United States are not covered. See the *Benefits Chart* and *Authorization and Notification* sections.

Emergency and Urgent Care Services

Emergency Services

Emergency services include evaluating and treating an illness, injury, symptom or condition so serious, including severe pain, that a reasonable person would seek care right away to avoid severe harm. This includes seeking treatment to stop the illness, injury, symptom or condition from getting worse.

Emergency services are covered whenever you need them, anywhere in the United States, from an in-network or non-network provider. To get help as quickly as possible call 911.

Our plan covers air and ground ambulance services to the emergency room or nearest medical facility when any other way could endanger your health. Emergency ambulance services are covered anywhere in the United States.

If you are admitted to a non-network hospital due to an emergency, UCare must be notified as soon as reasonably possible. The non-network hospital can call or fax UCare's Clinical Services department to report your admission.

If you must stay in a non-network hospital due to an emergency, your emergency coverage will continue at the in-network level until it is safe to move you to an in-network facility. At that time, UCare can help arrange for network providers to take over your care.

Be aware: UCare's cost-sharing for emergency room services from non-network providers is at the in-network benefit level. However, you are responsible for paying the non-network provider any

charges that exceed the allowed amount UCare will pay the provider. This amount can be costly for emergency room services. See the *Balance Billing* section to learn more.

If the services you need do not meet the definition of an emergency, refer to the *Benefits Chart* section to learn about your benefits.

To receive in-network benefits after an emergency, follow-up care or scheduled care must be obtained from an in-network provider.

Urgent Care

Urgent care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care that cannot be delayed until the next available clinic or office hours.

For a list of in-network urgent care providers, see your plan's *Provider Directory* or the *Search Network* tool at **ucare.org/searchnetwork**. You must get care from in-network providers to receive the highest level of benefit coverage. To find out how to get urgent care or care after normal business hours, call your primary care provider, or the UCare 24/7 Nurse Line. The Nurse Line is answered 24 hours a day, seven days a week. The phone number is on your member ID card.

Prescription Drugs

This plan has a prescription drug formulary. This is a list of generic and brand drugs that are covered by this plan. A generic drug is a prescription drug that has the same active ingredient as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes for many brand-name drugs. UCare uses industry standard resources to determine a drug's classification as either brand or generic. Some drugs identified as "generic" by a manufacturer, pharmacy or your provider may not be classified by UCare as a generic.

To be covered, a drug must be on our formulary, or a formulary exception must be obtained. To view the most recent formulary for this plan go to **ucare.org/searchdruglist**.

The formulary may change during the plan year. If you are affected by a drug coverage change, you will be notified 30 days in advance. You and your provider will be able to request and receive a formulary exception if the criteria are met.

You must fill your prescription at a network pharmacy to be covered. The *Provider Directory* and *Search Network* tool list in-network pharmacies. Go online to **ucare.org/searchnetwork** for the most current listing.

In a medical emergency, we cover prescriptions filled at a non-network pharmacy. However, the drug must be related to the emergency care. In this case, you will need to pay the full cost of the drug when you fill your prescription, rather than your normal share of the cost. UCare will then reimburse you the difference. Call Customer Service to learn how to be reimbursed for the cost of the drug.

The *Benefits Chart* in this Contract shows cost-sharing information for covered drugs.

Some drugs listed in the formulary have special requirements in order to be covered. They include:

- **Authorization:** Some drugs require you or your provider to get UCare's approval before you fill your prescription in order for UCare to cover the drug. The plan formulary states which drugs need authorization or prior approval.
- **Step therapy:** Even if a drug is on the formulary, you may have to try one or more similar drugs on the formulary before this drug will be covered. The plan formulary states which drugs require step therapy.
- **Quantity limits:** UCare limits the amount of some covered drugs you can receive each time you fill a prescription, including limits on refills or dosages. An example of drugs with quantity limits are opioids. The plan formulary states which drugs have quantity limits.

Specialty Drugs

Specialty drugs are injectable or oral drugs used to treat certain diseases that require complex therapies. These drugs often require special handling or monitoring by a pharmacist or nurse. If you use a

specialty drug, you or your doctor must contact the specialty pharmacy to order the drug. Your drug and any needed supplies will be shipped to your home, work or doctor's office.

Fairview Specialty Pharmacy is the only network provider of most specialty drugs for this plan. Fairview also provides clinical support to you and your caregivers. A Fairview pharmacist is on call 24 hours a day if you have an urgent need related to your specialty drug. Call Fairview Specialty Pharmacy at 1-800-595-7140 toll free. TTY users call the National Relay Center at 711 and ask for 1-800-595-7140.

Mail Order Pharmacy

You can fill prescriptions you take regularly through the Express Scripts Mail Order Pharmacy. You can order up to a 90-day supply of certain generic and brand drugs. You can get a 90-day supply of most generic drugs (Tier 1 and Tier 2) for the price of two copays.

To start using the Mail Order Pharmacy service:

- Create an account on Express-Scripts.com and follow the prompts or
- Call Express Scripts at 1-877-567-6320 or TTY: 1-800-716-3231 toll free

If you have questions or need help, call Express Scripts Customer Service at the numbers above.

Requesting a Formulary, Step Therapy or Drug Restriction Exception

If your doctor or prescriber believes you need coverage for a drug that is not on the formulary but is medically appropriate, you, your representative or doctor can ask UCare to make an exception and cover the drug. You can also request that we remove step therapy requirements, drug restrictions or limits.

For help requesting an exception, call Customer Service at the number on the inside front cover of this Contract. Or log in to your UCare member account and complete the Exception Request form.

Your doctor must submit a statement supporting the request. If your request to cover a non-formulary generic or brand drug is approved, you will pay the Tier 4 Non-Preferred Brand Drug cost share amount for the drug. Exception requests for lower cost sharing amounts for drugs on a higher tier will not be granted.

A formulary exception may be approved if your prescriber provides an oral or written statement to UCare stating one of these criteria has been met:

- Two or more of the drugs on the formulary (if available) to treat your condition would not be as effective as the non-formulary drug
- Two or more of the drugs on the formulary (if available) to treat your condition would have harmful medical effects
- The formulary drug(s) caused an adverse reaction
- The formulary drug(s) poses a risk to you
- The prescriber shows that a prescription drug must be dispensed as written to provide maximum medical benefit to you

Standard and Expedited exception requests

You (or your representative) and your prescriber will be told of UCare's determination (approval or denial) within 72 hours for a standard formulary exception request—and within 24 hours for an expedited exception request. Expedited exception requests can be made if you are suffering from a health condition that may seriously harm your life, health or ability to regain maximum function, or you are undergoing a treatment using a non-formulary drug. For both standard and expedited requests, if approved, the non-formulary drug will be covered for the duration of the prescription. This includes refills for the duration of your health condition or treatment related to the request for up to one year from date of approval.

If the standard or expedited formulary exception request is denied, you have the right to request an external appeal (see *Appeals and Complaints* section of this Contract). You (or your representative) and your prescriber will be notified of the external appeal decision within 72 hours of the request for a standard appeal—and within 24 hours of the request for an

expedited appeal. If your external appeal is approved, the non-formulary drug will be covered for the duration of your health condition, or treatment related to the request for up to one year from the date of approval.

Authorization and Notification

You, your representative or your provider are responsible for obtaining authorization from UCare, and/or sending notification to UCare when required. Authorization and notification apply to services from in-network and non-network providers.

For some services:

- Authorization is required before you receive the service
- Authorization may be required after a point in your treatment in order for the services to continue
- Notification may be required within a certain time period after the service begins

See the *Benefits Chart* section in this Contract to learn which services need prior authorization and/or notification.

For a list of medical, mental health and substance use disorder services that require authorization or notification, visit ucare.org. At the top, click on *Plan Resources*. Under the *Individual & Family Plans* tab open the *Prior Authorization Information (PDF)*. The list for Individual & Family Plans is on page 2. Authorization and notification requirements may change.

If you have questions about how to request approval or notify UCare, call Customer Service.

Drug and Medical Authorizations Approved by Previous Health Plan

If you are new to UCare and have a prior authorization for a drug or medical service from your former plan, UCare can honor the authorization for at least the first 60 days that you are in our plan. To obtain coverage for this 60-day period, you or your doctor's office must send UCare proof of the previous authorization. For continued coverage after 60 days, you or your provider should submit a request for a medical or drug exception (as explained in the previous section) before the 60-day period ends. For help requesting this 60-day coverage of a previously authorized drug or medical service, call Customer Service. The number is on the inside front cover of this Contract.

Continuity of Care

As a member, you have the right to continuity of care in some situations. This means you may be able to continue getting care from your provider, even if they are no longer in your plan's network. For example, if we end our network relationship with your provider without cause, your provider becomes a non-network provider. You may be able to keep getting care from that provider at the in-network benefit level for a period of time before you change to a new in-network provider.

To receive continuity of care, your provider must agree to follow UCare's authorization and notification requirements, provide us with all necessary medical information related to your care, and accept UCare's payment amount for covered services.

You can request that we approve continuity of care for up to 120 days for the following:

- An acute condition
- A life-threatening mental or physical illness
- Pregnancy beyond the first trimester
- A physical or mental disability defined as inability to engage in one or more major life activities, provided the disability has lasted or is expected to last at least one year, or can be expected to result in death
- A disabling or chronic condition in an acute phase
- For the rest of your life, if a doctor, advance practice registered nurse or physician's assistant certifies that you are expected to live 180 days or less

UCare will consider continuity of care for up to 120 days if:

- You are receiving culturally appropriate services, and there are no in-network providers with this expertise within the time and distance requirements
- You do not speak English, and an in-network provider cannot communicate with you either directly or through an interpreter within the time and distance requirements

We will not approve continuity of care if:

- Your provider ends its network contract with UCare
- We end our contract with your provider for cause

UCare will help you move to an in-network provider if you ask us. Call Customer Service at the number on the inside front cover of this Contract if you have questions about continuity of care.

Important Coverage Information

When new technologies enter the marketplace (devices, procedures or drugs):

- UCare's clinical and quality committees and medical directors carefully research and review new technologies before determining their medical necessity and/or appropriateness.
- UCare evaluates information from many sources including the Hayes, Inc. Technology Assessment Reports, published peer-reviewed medical literature, consensus statements and guidelines from national medical associations and physician specialty societies, the U.S. Food and Drug Administration (FDA), other regulatory bodies, and internal and external expert sources.
- UCare's medical policies do not imply coverage authorization, nor do they explain benefits.
- UCare encourages your doctors and health care team to talk openly with you. We do not restrict doctors from talking with you about care options, regardless of cost.

To learn more, visit the *About UCare* section at **ucare.org** and click *Important Coverage Information*. Information about our medical policies is available upon request.

Approved Clinical Trials

UCare does not discriminate against or deny members from participating in approved clinical trials. This plan covers routine costs related to a member being in an approved clinical trial. Routine costs are items and services that would be covered benefits for members who are not in an approved clinical trial.

UCare reserves the right to decide if a clinical trial is an approved clinical trial based on the law. To learn if a clinical trial is an approved clinical trial, please call Customer Service.

Health Club Savings Program

Receive up to $20 toward your monthly health club membership dues when you visit a participating health club at least 12 times per calendar month. If you have family coverage, you may add one covered dependent (age 18 or older) for a credit of up to $40 per month. To enroll in the program, show your UCare member ID card at the health club. To learn more, call Customer Service. Or visit **ucare.org/healthwellness** to find a participating health club near you.

This icon on your member ID card shows you are eligible.

Health and Wellness Discounts

WholeHealth Living™ Choices offers easy, online access to health and wellness discounts and alternative medicine practitioners. Discounts apply to non-covered benefits. Always check your plan for covered services.

- Access to more than 40,000 practitioners
- Discounts on brand-name health products
- Diverse network includes acupuncture, Tai Chi, massage, nutritionists and more
- Access these discounts from your UCare member account. Go to **ucare.org** and click on *Member Login*.

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Healthy Savings Program

The Healthy Savings program provides discounts on many healthy food items from trusted brands at grocery stores near you. Shop for the healthy foods that are advertised on the Healthy Savings website or mobile app, scan the barcode at check out, and get immediate savings. Learn more at **ucare.org/healthwellness**.

Community Education Class Discounts

Get up to a $15 discount on most community education classes in Minnesota. Check your local community education catalog or contact your local school district for class times and locations. To get your discount, simply show your UCare member ID card when enrolling in a class. There is a limit of three discounts in a calendar year (one per class enrollment).

UCare Tobacco Quit Line

If you'd like help learning how to live without tobacco or nicotine, the UCare Tobacco Quit Line provides these services free of charge:

- One-on-one phone coaching
- Quit guide booklet
- Quit aids, like nicotine patches and gum
- Members-only website for online support
- Text tips and reminders

To get started, call the tobacco quit line at 1-855-260-9713 toll free. Hearing impaired dial TTY 711 toll free, or visit online at **www.myquitforlife.com/ucare**.

Member Cost-Sharing

When you use your UCare benefits, you will likely have to pay for a portion of those services. This is called cost-sharing. Cost-sharing is in the form of a copayment, coinsurance or deductible. The amount you pay for covered services may vary based on the services received, and whether those services were from in-network or non-network providers. See the *Benefits Chart* section for details on cost-sharing amounts for specific benefits.

Cost-Sharing When Using In-Network Providers

You will get the highest level of coverage and minimize your out-of-pocket costs when you use in-network providers for covered services. UCare payments to in-network providers are based on the allowed amount. This is the fee that UCare has contracted with the provider to pay for a specific service. In-network providers cannot bill you for charges, other than cost-sharing, that exceed the allowed amount. Depending on the service, you may have to pay one or more of these types of cost-sharing:

- **Copayment** – a fixed amount (for example, $60) you pay for a covered service, usually when you receive the item or service.
- **Deductible** – the overall amount you have to pay for services before your health plan begins to pay.
- **Coinsurance** – your share or percent of the cost of a covered service (for example, 30%).

When you reach your in-network out-of-pocket limit, the plan will pay 100% of the allowed amount for covered services from in-network providers.

You are responsible for paying 100% of the cost for services not covered by this Contract.

Upon request, UCare will give you a good faith estimate of your total out-of-pocket cost(s) for a specific service from a specific in-network provider. You can expect to receive this estimate within 10 business days. To make a request, call Customer Service. The number is inside the front cover of this Contract and on the back of your member ID card.

Cost-Sharing When Using Non-Network Providers

Providers that do not have a network contract with UCare are non-network providers. In most cases, you will pay more out-of-pocket when you get care from non-network providers.

There are a few cases when coverage at non-network providers is the same as at in-network providers. They are emergency services, testing and treatment of sexually transmitted diseases, services to diagnose infertility, and services related to conceiving and bearing children.

UCare's payments to non-network providers are based on the allowed amount we pay in-network providers (see the *How UCare Pays Providers* section to learn more). Some non-network providers may consider this payment in full, but they are not required to do so. When using non-network providers, you may have to pay one or more of the following:

- Copayment
- Coinsurance
- Deductible
- Charges that remain if the provider does not accept UCare's allowed amount as payment in full. See the *Balance Billing* and *How UCare Pays Providers* sections.

Cost-sharing for services from non-network providers has a separate deductible. Plus there is no out-of-pocket limit for non-network services.

You are responsible for paying providers for services not covered by this Contract.

Unauthorized Provider Services

In some cases, you might receive covered services from a non-network provider while you are at an in-network hospital or ambulatory surgery center. This may happen without your knowledge.

Examples are:

- When an in-network provider sends your specimen taken at an in-network facility to a non-network laboratory, pathologist or other testing facility.
- When an in-network hospital uses a non-network anesthesiologist, radiologist or other clinician to deliver services because an in-network provider is not available.
- When unforeseen covered services are needed and delivered by a non-network provider while at an in-network hospital or ambulatory surgery center.

These services are considered unauthorized if you did not give your provider advance written consent stating that the services may result in costs not covered by UCare. If you receive unauthorized services from a non-network provider, state law requires that your plan cost-sharing amount be the same as what you would pay in-network. You may be billed by the non-network provider for additional costs, such as non-covered services or the difference between the provider's billed amount and UCare's allowed amount (balance billing). UCare will attempt to negotiate a reimbursement for these services. If you have questions about unauthorized provider services, call Customer Service.

Balance Billing

UCare pays up to an allowed amount for each covered service you receive from a non-network provider. Our payment may be less than the charges billed by the non-network provider. If you receive services from a non-network provider and are billed an amount that is higher than UCare's allowed amount, you are responsible for paying the non-network provider the difference. This is called balance billing. Balance billed payments do not count toward your non-network deductible or out-of-pocket limit.

In-network providers are not allowed to bill you for more than the cost of UCare's allowed amount. However, they can bill you for any cost-sharing including copayment, deductible or coinsurance.

Out-of-Pocket Limit

Out-of-pocket limit is the maximum amount you have to pay out-of-pocket for in-network copayments, coinsurance and deductibles for covered services in a calendar year. After you reach your plan's individual or family out-of-pocket limit, the plan pays 100% of the cost for in-network covered services for the rest of the year. The cost-share amounts you pay for copayments and coinsurance for in-network covered services count toward your out-of-pocket limit.

Amounts you pay for plan premiums, balance-billed charges from non-network providers, and cost-share amounts paid for non-covered services do not count toward your out-of-pocket limit.

There is **no** out-of-pocket limit for covered services from non-network providers.

Embedded Deductible and Out-of-Pocket Limit

If you have a family plan, it has an embedded deductible and out-of-pocket limit. If you or a family member reaches the individual deductible or out-of-pocket limit, coverage will begin even if your overall family deductible/out-of-pocket limit is not met. Any amount paid toward an individual's deductible/out-of-pocket limit also applies toward the family's deductible/out-of-pocket limit. When the family deductible/out-of-pocket limit is met, the plan covers charges for any family member.

For example, if your family deductible is $1,000 and the individual deductible is $500 and your spouse has $500 in medical bills, his or her deductible is met even though the family deductible may not have been met yet. At this point, your spouse is only responsible for the amount of coinsurance required until he or she meets their individual out-of-pocket limit.

How UCare Pays Providers

This section describes how we most often pay providers for health services.

In-Network Providers

In-network providers are paid according to the terms of their agreement with UCare. Payment terms may differ by plan. Payment methods are intended to promote efficient and effective delivery of health care. They are not intended to affect your access to health care.

Payment methods may include, but are not limited to:

- Payments based on the type or quantity of services received (fee-for-service)
- A fee for a certain time period of care or health event

Payment methods to network providers may change over time, and may vary by provider. The primary method of provider payment for this plan is fee-for-service.

Fee-for-service payment means that UCare pays the in-network provider a fee for each service provided, based on a set fee schedule. Under this agreement, in-network providers are typically paid an amount that is less than what they would have otherwise billed. The fee may be a set percentage of the in-network provider's charge. The UCare amount paid to the in-network provider, less any member copayment, coinsurance or deductible, is considered payment in full.

You are not responsible for any difference between these payments and the provider's billed charges.

Non-Network Providers

For each covered service received from a non-network provider, UCare pays that provider up to an allowed amount. This payment may be less than the charges billed by the non-network provider. If you receive services from a non-network provider and are billed an amount greater than UCare's allowed amount, you may have to pay the difference to the provider. This is called balance billing. These charges will not apply toward your non-network deductible or out-of-pocket limit. (See the *Balance Billing* section.)

Your out-of-pocket costs for non-network provider services do not count toward your out-of-pocket limit, except in certain cases, like emergency care. You usually pay more when using non-network providers.

Benefits Chart

All cost-sharing amounts in this *Benefits Chart* are based on UCare's allowed amount paid to providers. When you receive services from a non-network provider, you are responsible for paying the provider any difference between UCare's allowed amount and the non-network provider's billed charges (unless an exception applies).

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
DEDUCTIBLE		
Your plan's deductible is the overall amount you pay for certain services each year before UCare starts to pay. Some services are covered before the deductible is met. Single coverage/family coverage. The family deductible is embedded. (See the *Definitions* section for an explanation of embedded deductible.)	$2,900/$5,800	$5,800/$11,600
OUT-OF-POCKET LIMIT		
This is the maximum amount you have to pay for in-network covered services in a calendar year. Single coverage/family coverage. The family out-of-pocket limit is embedded. (See the *Definitions* section for an explanation.)	$7,900/$15,800	No limit.
AMBULANCE – EMERGENCY TRANSPORTATION		
UCare covers emergency, medically necessary and appropriate air or ground ambulance transportation to provide basic or advanced life support to the nearest emergency room or medical facility equipped to treat the condition.	You pay 30% after the in-network deductible has been met.	You pay 30% after the **in-network** deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
AMBULANCE – NON-EMERGENCY MEDICAL TRANSPORTATION		
Transfers between hospitals for treatment that is not available from the initial hospital are covered, if ordered by an in-network doctor. Transfers from a hospital to home or other facility are covered if medical supervision is needed on the way.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
CHIROPRACTIC CARE		
UCare covers chiropractic care to diagnose and treat acute conditions related to the muscles, skeleton and nerves. Covered services include office visit, spinal adjustment, therapeutic exercises, manual manipulation and other non-invasive therapies. Massage therapy is covered if performed with other treatment methods by a chiropractor. It must be part of a prescribed treatment plan and cannot be billed separately.	For each of the first three office visits in a plan year, you pay $30. After three visits you pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Services not covered include: • Acupuncture • Massage for the comfort or convenience of the member, or related to therapeutic massage • Treatment when there is no significant, measurable or quantifiable progress over a period of time		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
DENTAL – ACCIDENTAL/MEDICAL		
This plan is not a comprehensive dental plan. Only these medically necessary services are covered: 1. **Accidental Dental Services:** We cover dental services to treat and restore damage to sound, natural, unrestored teeth due to an injury. Coverage is for damage caused by external trauma to the face and mouth only, not for cracked or broken teeth due to biting or chewing. Coverage includes these procedures directly related to the injury: • Initial exam and x-rays • Restorations • Root canals • Crowns • Surgical procedures and extraction (removal) Treatment and/or restoration must be started within six months of the date of injury. Coverage is limited to the initial treatment and/or initial restoration. 2. **Outpatient Dental Services:** Coverage is limited to dental services to treat an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions. 3. **Hospitalization and Anesthesia for Dental Care:** This is limited to charges incurred by a member who (1) is a child under age 5, or (2) is severely disabled, or (3) is determined by a physician to be unable to cooperate with dental care under local anesthesia; has a medical condition, and needs hospitalization or general anesthesia for dental care treatment. Coverage is limited to facility and anesthesia charges.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
4. **Oral Surgery:** Coverage is limited to treatment of medical conditions requiring oral surgery, such as oral neoplasm, non-dental cysts, fracture of the jaws and trauma of the mouth and jaws. 5. **Treatment of Cleft Lip and Cleft Palate:** We cover treatment of cleft lip and cleft palate of a dependent child under age 19. Coverage includes orthodontic treatment and oral surgery directly related to the cleft. Benefits for eligible dependents 19 and older are limited to inpatient or outpatient expenses arising from medical and dental treatment scheduled or begun prior to the dependent turning age 19. We do not cover dental services unless they are required to treat cleft lip or cleft palate. If a dependent child covered under this Contract is also covered under a dental plan that includes orthodontic services, that dental plan shall be primary for the necessary orthodontic services. Oral appliances are subject to the same copayment conditions and limits as durable medical equipment. 6. **Treatment of Temporomandibular Joint Disorder (TMJ/TMD) and Craniomandibular Disorder (CMD):** We cover surgical and non-surgical treatment of TMJ and CMD.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

Services not covered include:

- Oral surgery to remove wisdom teeth
- Treatment of cracked or broken teeth due to biting or chewing
- Accident-related dental services if treatment is provided to teeth that are not sound and natural, and to teeth that have been restored
- Services begun after six months from the date of the injury, received beyond the initial treatment or restoration, or received after 24 months from the date of injury
- Dental implants (tooth replacement)
- Osteotomies and other procedures related to the fitting of dentures or dental implants
- Procedures that are non-accidental or injury related or cosmetic in nature
- Dental treatment, procedures and services not listed in this Contract

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
DENTAL – PEDIATRIC BASIC/MAJOR CARE		
UCare covers these pediatric dental services for members under age 19. Restorative services: • Amalgam and resin-based composite fillings • Root canal • Extractions • Periodontal scaling and root planing (once every 24 months) • Full mouth debridement (once per lifetime) • Crowns – limited to one per tooth, per 60 months • Some inlays and onlays – one per tooth, per 60 months • Complete and partial dentures, bridges – limited to one in a 60-month period, adjustments, repairs, relines and rebases, every 36 months • Some complex oral surgery • Implants – one every 60 months	You pay 30% after the in-network deductible has been met.	Not covered.
Dental services not covered include: • Dental services for members 19 and older • Temporary services (e.g., provisional crowns, interim dentures)		

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
DENTAL – PEDIATRIC CHECK-UP		
These pediatric dental services are covered for members under age 19: • Periodic oral evaluation – one every six months • Limited oral evaluation – one every six months • Oral evaluation – one every six months • Periodontal evaluation – one every six months • Dental x-rays – complete series (including bitewings) – one every 60 months • Dental x-rays – periapical and occlusal film • Bitewings – one set every six months • Vertical bitewings – seven to eight films – one set every six months • Panoramic film – one film every 60 months • Cephalometric radiographic image • Oral / Facial photographic images • Interpretation of diagnostic image • Diagnostic models • Prophylaxis – one every six months • Topical application of fluoride (excluding prophylaxis) – two every 12 months • Sealant – per tooth – unrestored permanent molars – one sealant per tooth every 36 months • Space maintainers – fixed and removable – unilateral and bilateral • Re-cementing space maintainer	You pay nothing.	You pay 50% after the non-network deductible has been met.
DIABETES EDUCATION		
UCare covers education and self-training to help manage diabetes. Includes medical nutrition therapy.	You pay nothing.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
DRUGS – GENERIC AND BRAND		
Preferred Generic Drugs — Tier 1 UCare covers drugs identified as preferred generic prescription drugs on the formulary.	You pay $10 for up to a 30-day supply. $20 for up to 90-day extended supply at a participating in-network retail or mail order pharmacy.	Prescription drugs from a non-network pharmacy are not covered.
Non-Preferred Generic Drugs — Tier 2 UCare covers drugs identified as non-preferred generic prescription drugs on the formulary.	You pay $20 for up to a 30-day supply. $40 for up to 90-day extended supply at a participating in-network retail or mail order pharmacy.	Prescription drugs from a non-network pharmacy are not covered.
Preferred Brand Drugs — Tier 3 UCare covers drugs identified as preferred brand prescription drugs on the formulary. **Cost-sharing for diabetes medications:** You will pay no more than $25 for a 30-day supply of insulin and select brand diabetes medications on the formulary. Your cost could be less if you have met your plan deductible or out-of-pocket limit.	You pay $175 per prescription for up to a 30-day supply.	Prescription drugs from a non-network pharmacy are not covered.
Non-Preferred Brand Drugs — Tier 4 UCare covers drugs identified as non-preferred brand prescription drugs on the formulary.	You pay 40% after the in-network deductible has been met.	Prescription drugs from a non-network pharmacy are not covered.
Note: The most recent formulary (drug list) for this plan is at ucare.org/searchdruglist.		

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
DRUGS – SPECIALTY		
Specialty Drugs — Tier 5 UCare covers generic and brand specialty drugs on the formulary. Fairview Specialty Pharmacy is the only in-network provider of most specialty drugs for plan members. Specialty drugs are injectable or oral drugs. They often require special handling or monitoring by a pharmacist or nurse. If you use a specialty drug, your specialty pharmacy will work with you and your provider to get you needed clinical support. Authorization may be required. Ask your doctor or prescriber if authorization is needed.	You pay 40% after the in-network deductible has been met.	Specialty drugs from a non-network pharmacy are not covered.
Non-formulary specialty drugs are not covered unless an exception is granted.		
Notice regarding the use of manufacturer savings cards, coupons or rebates UCare and Fairview Specialty Pharmacy welcome the use of drug manufacturer savings cards, coupons or rebates to help pay the cost of specialty drugs. However, only the amount you pay out-of-pocket for your specialty drug will apply to your plan deductible and/or out-of-pocket limit. Savings card, coupon or rebate dollar amounts will not count toward your plan deductible and/or out-of-pocket limit. This ensures that you receive credit for what you have actually paid out-of-pocket, not the amount a manufacturer has contributed toward your specialty drug purchase. If you have questions, please call Customer Service.		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*

More Drug Coverage Information

Opiate antagonists to treat an opiate overdose are covered when prescribed by an in-network pharmacist, physician, physician assistant or advanced practice nurse practitioner or when administered during emergency treatment.

The most recent formulary (drug list) for this plan is at **ucare.org/searchdruglist**.

To be covered, over-the-counter (OTC) drugs must be prescribed and on our formulary. This applies to drugs covered as part of the Essential Health Benefits, such as emergency contraception, tobacco cessation and diabetic supplies.

Diabetic supplies and equipment are limited to certain models and brands. See UCare's formulary and the *Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies* section of this *Benefits Chart*.

We cover women's FDA-approved contraceptives on the formulary when received at an in-network pharmacy (see UCare's formulary and the *Preventive Care, Screenings and Immunizations* section of this *Benefits Chart*), including when prescribed at the pharmacy.

We cover FDA-approved drugs for pre-exposure prophylaxis for the prevention of HIV infection (individual must be HIV negative).

We cover all FDA-approved tobacco cessation drugs, also called Nicotine Replacement Therapy (NRT). There is no charge for tobacco cessation drugs, including over-the-counter drugs that are on the formulary and obtained with a prescription at an in-network pharmacy, including when prescribed at the pharmacy.

To learn about our services to help quit tobacco, see the UCare Tobacco Quit Line section or call 1-855-260-9713 toll free. Hearing impaired dial TTY 711 toll free.

Medication Therapy Management — UCare covers services provided by, or under the supervision of, a licensed pharmacist for members taking four or more prescriptions to treat chronic medical conditions. Medication therapy management services include a comprehensive medication review, communicating with the member's primary care providers, and verbal medication education and training. You pay nothing for these services when they are provided by an in-network pharmacist.

Authorization may be required. See the *Authorization and Notification* section of this Contract.

Prescription drugs not covered include:

- Non-formulary brand and generic drugs, unless an exception is granted
- Drugs for weight loss
- Drugs used for cosmetic purposes
- Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft
- Non-prescription (over-the-counter) drugs, unless on the formulary. This includes, but is not limited to, vitamins, supplements, homeopathic remedies and non-FDA approved drugs.
- All drugs to treat sexual dysfunction
- All drugs to treat infertility

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND MEDICAL SUPPLIES		
UCare covers the equipment and services described below. • Diabetic supplies and equipment for members with gestational, Type I or Type II diabetes: 1. Glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies 2. Custom molded shoes or depth shoes, one pair per calendar year with up to two pairs of orthotic inserts. Includes fitting by orthotist. • Total parenteral nutrition/intravenous (TPN/IV) therapy, equipment, supplies and drugs related to IV therapy and IV line care kits • Enteral feedings required to sustain life • Special dietary treatment for Phenylketonuria (PKU) and oral amino acid-based elemental formula • Wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices and hospital beds • Prosthetics, including artificial limbs and eyes. See the *Reconstructive Surgery* section for breast prosthesis coverage. • Repair, replacement or revision of durable medical equipment due to normal wear and use • Medical supplies, including splints, surgical stockings, casts and dressings	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met. No coverage for hearing aids.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
• External hearing aids (including osseointegrated or bone anchored aids) for members 18 or younger with a hearing loss not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years. • Oral appliances for cleft lip and cleft palate • Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. One prosthesis per person per calendar year.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met. No coverage for hearing aids.

Coverage of durable medical equipment is **limited** by the following:

Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary.

For prosthetic benefits, other than hair prostheses (i.e., wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece or equipment or service that is effective, medically necessary and enables members to conduct standard activities of daily living.

We have the right to determine if an item will be approved for rental or purchase.

Durable medical equipment and supplies must be obtained from or repaired by approved vendors.

Covered services and supplies are based on UCare coverage and medical polices. These policies are subject to periodic review and change by the medical directors.

Authorizations may be required. See the *Authorization and Notification* section in this Contract.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
Services not covered include, but are not limited to: • Replacement or repair of any covered items that are lost, stolen, damaged or destroyed by member misuse, abuse or carelessness • Duplicate or similar items • Labor and charges to repair any covered items that exceed the cost of replacement by an approved vendor • Sales tax, mailing, delivery charges and service call charges • Items that are mostly educational in nature or for hygiene, vocation, comfort, ease or recreation • Communication aids and devices: equipment to create, replace or augment communication abilities, speech processors, receivers, communication boards, computers, iPads, tablets or electronic-assisted communication, except as described in this Contract • Hearing aids (implantable and external, including osseointegrated or bone anchored) and fitting of hearing aids for members age 19 and older (except as required by law). This exclusion does not apply to cochlear implants. • Hearing aid batteries • Household equipment that has customary use other than medical. This includes exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses and waterbeds. • Household fixtures including escalators, elevators, ramps, swimming pools and saunas • Changes to the home structure including wiring, plumbing, or charges to install equipment • Vehicle, car or van changes including hand brakes, hydraulic lifts and car carrier • Rental equipment while your equipment is being repaired by non-contracted vendors, beyond a one-month rental of medically necessary equipment • Other equipment and supplies that UCare determines are not eligible for coverage • Enteral nutrition products given orally and related supplies • Food thickeners, baby food and grocery items that can be blended and used with enteral products • Over-the-counter orthotics, appliances and supplies		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
EMERGENCY ROOM (ER) SERVICES		
Emergency services include evaluating and treating an illness, injury, symptom or condition so serious, including severe pain, that a reasonable person would seek care right away to stabilize health, preserve life or avoid severe harm. This includes treatment to stop the illness, injury, symptom, or condition from getting worse. If you are confined in a non-network hospital or facility due to an emergency, your emergency coverage continues until your attending physician agrees it is safe to discharge or transfer you to an in-network hospital or facility. To be eligible for in-network benefits after an emergency, follow-up care or scheduled care must be from an in-network provider. **Note:** Some services related to an emergency room visit may be provided outside of the emergency room. Examples include lab tests and radiology services. Services such as these may require separate cost-sharing in addition to the emergency room cost-sharing amount. **Be aware:** UCare's cost-sharing for emergency room services from non-network providers is at the in-network benefit level. However, you are responsible for paying the non-network provider any charges that exceed the allowed amount UCare will pay the provider. This amount can be costly for emergency room services. See the *Balance Billing* section to learn more.	For the first emergency room visit, you pay $250 copay. After one visit you pay 30% after the in-network deductible has been met. You do not pay a copay if you are admitted to the hospital on an inpatient basis within 24 hours for the same condition.	For the first emergency room visit, you pay $250 copay. After one visit you pay 30% after the **in-network** deductible has been met. You do not pay a copay if you are admitted to the hospital on an inpatient basis within 24 hours for the same condition.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
EYEWEAR FOR CHILDREN		
UCare covers one pair of eyewear (frame and lenses) each calendar year, for members under age 19. This includes polycarbonate lenses with scratch coating. In place of eyeglasses, we cover one pair of standard contact lenses, or one 12-month series of planned replacement lenses per calendar year to correct vision. This includes lens fitting and exam. Coverage is limited to the most cost-effective option. When you purchase lenses, frames or optical devices that cost more than what is considered medically necessary by a UCare medical director, you must pay the difference in purchase and maintenance cost.	You pay 30% after the in-network deductible has been met. Limit of one item per calendar year.	Not covered.

Services not covered include:

- Eyeglasses and contacts for members 19 and older, except as described in the *Vision* section of this *Benefits Chart*
- Safety glasses or goggles for sports or job-related reasons
- Protective coating for plastic lenses
- Non-prescription lenses, including reading glasses
- Two pairs of eyeglasses in lieu of bifocals
- Sunglasses, sport lenses and sport frames
- Special lens designs and coatings not medically necessary, including special lenses and lens modifications that do not correct vision problems. This includes tinted lenses, transition (photochromic) lenses, high-index lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating.
- Repairs to frames and lenses
- Replacement of stolen, broken or lost eyewear
- Replacement of lenses or frames due to provider error in prescribing, frame selection or measurement. The provider who made the error is responsible for the cost of correcting the error.
- Color contact lenses
- Daily wear specialty contact lenses
- Contact lens supplies
- Contact lens insurance

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
FAMILY PLANNING		
UCare covers education and counseling for the voluntary planning of conceiving and bearing children. Coverage is at the same level for in-network and non-network providers. **Note:** Many services related to family planning, including female contraceptive services, are covered at $0 cost-sharing under the *Preventive Care, Screenings and Immunizations* section of this *Benefits Chart*. See that section to learn more. See the *Infertility Diagnosis* section for covered services to diagnose infertility.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met. Lab services and testing: You pay 30% after the in-network deductible has been met.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the **in-network** deductible has been met. Lab services and testing: You pay 30% after the **in-network** deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
HOME HEALTH SERVICES		
Home health services are covered when they are provided as medically necessary rehabilitative or habilitative care, terminal care or maternity care. These services must be ordered by a doctor and be part of a written care plan. Home health services are limited to 120 visits per year. UCare covers: • Home health aide and nursing services when provided in your home, if you are homebound. Homebound means you are unable to leave your home without great effort due to a medical condition. Lack of transportation does not qualify for homebound status. • Skilled nursing services (i.e., wound care) • Physical therapy, occupational therapy, speech therapy and respiratory therapy • Prenatal services for high-risk pregnancy, and postnatal services • Phototherapy for newborns with high bilirubin levels, child health supervision services • Total parenteral nutrition or intravenous (TPN/IV) therapy, equipment supplies and drugs related to IV therapy. IV line care kits are covered under *Durable Medical Equipment*. You do not need to be homebound to receive TPN or IV therapy.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
• **Palliative Care** is special care if you have a life-threatening, non-curable condition with a prognosis of two years or less to live. Palliative care seeks to relieve pain, manage symptoms and improve quality of life. This includes education and setting care goals. You are not required to be homebound for a limited number of palliative care home visits. You may be eligible for more palliative care visits under the home health services benefit if you are homebound and meet all other requirements in this section.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
A service is not a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. When a service (e.g., tracheotomy suctioning or ventilator monitoring) can be safely performed by a non-medical person (or self-administered) without the direct supervision of a licensed nurse, the service shall not be viewed as a skilled nursing service, whether or not a skilled nurse provides the service. The absence of a competent person to provide a non-skilled service does not make it a skilled service when a skilled nurse provides it. Only the skilled nursing components of so-called "blended" services (i.e., services that include skilled and non-skilled components) are covered under this Contract. Authorization (prior approval) is required.		
Services not covered include: • Planned home births • Home health services are **not** a substitute for a primary care giver in the home or as relief (respite) for a primary care giver in the home. We do **not** reimburse family members or residents in your home for the above services.		

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
HOME HOSPICE SERVICES		
UCare covers home hospice services if you are terminally ill and in a home hospice program. To be eligible for the home hospice program you must: • Have a terminal condition with a prognosis of six months or less to live • Choose a treatment focus of comfort and support services • Continue to meet the terminally ill prognosis You may withdraw from the home hospice program (and re-enroll) at any time. Hospice services include these services if provided according to an approved hospice treatment: • Home health services – We cover part-time care in your home by a hospice team which may include a doctor, nurse, social worker and spiritual counselor; and home health services – We cover one or more periods of continuous care in your home or in a setting that provides day care to manage pain or symptoms • Inpatient services: We cover inpatient hospital services	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
• Other covered services include: – Respite care in your home or in an appropriate facility, to give your primary caregivers (i.e., family members or friends) rest and/or relief as necessary to continue to take care of you at home. Respite care is limited to five consecutive days per episode. Respite care and continuous care combined are limited to 30 days per calendar year. – Drugs to manage pain and symptoms – Semi-electric hospital beds and other durable medical equipment – Emergency and non-emergency care	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

Services not covered include:

- Financial and legal counseling services
- Housekeeping and meal services in the member's home
- Custodial care related to hospice services, whether in the home or in a nursing home
- Services provided by the member's family or residents in the member's home

These definitions apply:

Part-time. Up to two hours of service per day; more is considered continuous care.

Continuous care. From two to 12 hours of service per day provided by a registered nurse, licensed practical nurse or home health aide, during a crisis to keep a terminally ill patient at home.

Appropriate facility. A nursing home, hospice residence or other inpatient facility.

Custodial care related to hospice services. Assisting in the activities of daily living and the care needed by a terminally ill member that can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the member's home care.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
INFERTILITY DIAGNOSIS		
UCare covers services to diagnose infertility. These include: office visits, consultations, procedures and tests needed to diagnose infertility. Some services received during an office visit may be covered under another benefit in the Contract (e.g., diagnostic tests). The most appropriate benefit in the Contract will apply for each service received during an office visit.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met. Labs, testing and outpatient surgery: You pay 30% after the in-network deductible has been met.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the **in-network** deductible has been met. Labs, testing and outpatient surgery: You pay 30% after the **in-network** deductible has been met.
Services not covered include, but are not limited to: • Infertility treatment including: office visits, laboratory and diagnostic imaging services; surrogate pregnancy and related obstetric/maternity benefits; and sperm, ova or embryo acquisition, retrieval or storage • Reversal of sterilization • Assisted reproduction including artificial insemination (AI), intrauterine insemination (IUI), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all related charges • All drugs used to treat infertility		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
INJECTIONS		
UCare covers injections, including allergy shots given in the doctor's office. Some medical injection drugs given in the doctor's office may require your doctor to request authorization. Some vaccines and immunizations, including flu shots are preventive and covered under the *Preventive Care, Screenings and Immunizations* section of this Contract.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
INPATIENT HOSPITAL SERVICES		
UCare covers medical and surgical services to treat acute illness and injury that require the level of care provided only in an acute care hospital or facility. UCare requires hospitals and providers to notify us in advance of all inpatient acute care, medical and surgical admissions and requests for extensions. This includes long-term acute care (LTAC) and acute inpatient rehabilitation. Inpatient hospital services include: • Room and board (includes meals) • Use of operating and recovery rooms • Intensive care • General nursing care • Anesthesia • Laboratory and diagnostic imaging services • Radiation therapy • Physical, occupational, respiratory and speech therapy • Drugs given during treatment • Blood and blood products (unless replaced), and blood derivatives • Other diagnostic and treatment-related hospital services • Physician and other medical and surgical services provided while in the hospital Notifications are required.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
Inpatient services not covered include items for personal convenience. See *Exclusions – Services Not Covered*.		
INPATIENT HOSPITAL SERVICES – MATERNITY CARE		
Covered inpatient hospital services include: • Room and board (meals) • Use of operating, maternity and recovery rooms • Intensive care • Newborn nursery • General nursing care • Anesthesia • Laboratory and diagnostic imaging services • Physical, occupational, respiratory and speech therapy • Drugs given for treatment • Blood and blood products (unless replaced), and blood derivatives • Other diagnostic and treatment-related hospital services • Physician and other medical and surgical services provided while in the hospital	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
UCare covers inpatient care for mother and newborn child for at least 48 hours after a vaginal delivery, and 96 hours after a cesarean section delivery. Your provider is allowed to discharge you or your newborn sooner than that, but only if you both agree. In any case, UCare may not require a provider to obtain authorization from UCare for a length of stay of 48 hours or less (or 96 hours or less, as applicable). If the length of stay is less than these minimum hours, we also cover at least one home visit by a registered nurse for post-delivery care. The visit must be within four days of the mother and newborn child being discharged. Services provided by the registered nurse include, but are not limited to: parent education; help and training in breast and bottle feeding; and necessary and appropriate clinical tests. We will not compensate or provide other non-medical incentives to encourage a mother and newborn to leave inpatient care before the minimum times stated. Notifications are required.		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
Services not covered include: • Services from a doula • Childbirth and other educational classes • Services for or related to adoption fees • Services for or related to a surrogate pregnancy of a non-member. This includes diagnostic screening, physician services, reproduction treatments and prenatal/delivery/postnatal services. • Services for or related to preserving, storing and thawing of human tissue. This includes, but is not limited to: sperm, ova, embryos, stem cells, cord blood, and other human tissue. • Private duty nursing services • Charges for planned home births • Services and items for personal convenience, such as television rental		
LABORATORY SERVICES		
UCare covers medically necessary laboratory tests, when ordered by a provider and conducted in a clinic or outpatient hospital. Some laboratory services are covered at the benefit level shown in the *Preventive Care, Screenings and Immunizations* section of this Benefits Chart.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*

Mental Health Parity and Addiction Equality Act

State and federal law requires <u>inpatient</u> and <u>outpatient</u> mental health services be covered on the same basis as other medical/surgical services. This means mental health treatment, limits (such as prior authorization and medical necessity) and member cost-sharing can be no more restrictive than similar medical benefits. If you have questions or concerns, call Customer Service. You can also file a complaint with UCare or the Minnesota Department of Health.

MENTAL HEALTH INPATIENT AND RESIDENTIAL SERVICES		
UCare covers services in an acute care hospital or licensed residential facility to evaluate and treat a mental health disorder or emotional disturbance. Services must be ordered by an authorized provider or medical doctor. We cover the evaluation and treatment of a mental health disorder, emotional disturbance and severe emotional disturbance in a residential facility as an alternative to inpatient hospital care when: • The member has been diagnosed with severe and persistent mental illness, serious mental illness, an emotional disturbance or severe emotional disturbance by a qualified mental health provider or medical doctor, and • The treatment facility is licensed by the state in which the service is provided We cover the evaluation and treatment of eating disorders in a residential facility as an alternative to inpatient hospital care when: • The member has been diagnosed with an eating disorder by a qualified mental health provider or medical doctor, and • The facility is licensed by the state in which the service is provided UCare notifications are required and prior approvals may be required. See the *Authorization and Notification* section in this Contract.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
Services not covered include: • Shelters, correctional and detention centers, transitional facilities (halfway houses), group residential homes, foster care services and wilderness programs • Respite or custodial care • Private room, except when it is medically necessary or the only option • Convenience items		

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
MENTAL HEALTH OUTPATIENT SERVICES, INCLUDING OFFICE VISITS		
UCare covers medically necessary office visit and outpatient professional mental health services. A comprehensive diagnostic assessment of each patient will be the basis for a determination by a mental health professional concerning the appropriate treatment and the extent of services required. The most appropriate benefit will apply for each service received. Covered services for a diagnosed mental health condition include: • Individual, group and family therapy • Diagnostic assessment • Medication management provided by a medical doctor or certified nurse practitioner • Psychological and neuropsychological testing by a qualified licensed psychologist • Day treatment (adult and child) in a licensed program • Mental health crisis intervention • Intensive outpatient services • Partial hospital program in a hospital or community mental health center • Treatment of a gambling disorder **Telemedicine/Telehealth:** UCare covers interactive audio-visual visits that allow providers to evaluate, diagnose and treat you without an in-person visit. Telemedicine is often used for follow-up visits, to manage chronic conditions and medications, to consult with specialists, and other clinical services. Office visit cost-sharing applies to telemedicine/telehealth. **Note:** Telemedicine for your primary care, specialist or other provider visit is not the same as online visits using virtuwell.com and/or oncare.org. Online visits are for treating minor conditions (common cold, rashes, etc.) and appointments are not needed. See the *Online Visits (E-Visits)* section in this Contract.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
We also cover mental health treatment ordered by a Minnesota court under a valid court order based on an assessment by a licensed psychiatrist or doctoral-level licensed psychologist. The evaluation must include a diagnosis and a treatment plan. UCare must be given a copy of the court order and assessment. We cover the initial assessment upon which the court order was based if it was done by an in-network provider. We also cover the initial mental health assessment of a child, regardless of whether that evaluation leads to a court order for treatment, if the evaluation is ordered by a Minnesota juvenile court. If UCare or an in-network provider determines that no structured treatment is necessary, you are entitled to a second opinion by a health care professional not affiliated with UCare who is qualified to diagnose and treat the condition. We will consider the second opinion but are not obligated to accept it. There is no cost to you for this second opinion. UCare authorizations or notifications may be required for select services. See the *Authorization and Notification* section in this Contract.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

Mental health services not covered include:

- Intensive behavioral therapy programs for the treatment of autism spectrum disorders, including Applied Behavioral Analysis therapy (ABA), Intensive Early Intervention Behavioral Therapy (IEIBT) and Lovaas
- Religious counseling, marital/relationship counseling and sex therapy
- Recreational therapy
- Chelation therapy
- Services received from providers or paraprofessionals who are not fully qualified and licensed to practice
- Vocational training and employment services

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
OFFICE VISITS		
UCare covers medically necessary services from doctors and other health care providers delivered in an office setting. Some services or drugs received during an office visit may be covered under another benefit in this Contract (e.g., diagnostic tests, imaging and injections). The most appropriate benefit will apply for each service received during an office visit. **Telemedicine/Telehealth:** UCare covers interactive audio-visual visits that allow providers to evaluate, diagnose and treat you without an in-person visit. Telemedicine is often used for follow-up visits, to manage chronic conditions and medications, to consult with specialists, and other clinical services. Office visit cost-sharing applies to telemedicine/telehealth. **Note:** Telemedicine for your primary care, specialist or other provider visit is not the same as online visits using virtuwell.com and/or oncare.org. Online visits are for treating minor conditions (common cold, rashes, etc.) and appointments are not needed. See the *Online Visits (E-Visits)* section in this Contract that follows. We also cover the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court. Eligible office visits include: • Primary care • Specialist • Urgent care • Mental health • Substance use • Other office visits (nurse, physician assistant) • Physical therapy services • Occupational therapy services • Speech therapy services • Chiropractic services	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits. After three visits you pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
These types of services are not covered in the office visit benefit: • Dental • Home health • Home hospice **Note:** This benefit does not cover facility or hospital fees from locations using hospital-based billing practices. See the *Outpatient Facility (e.g., Ambulatory Surgery Center)* and *Outpatient Surgery Physician Services* section of the *Benefits Chart*. If you are unsure if your provider uses these billing practices, contact them.		
ONLINE VISITS (E-VISITS)		
UCare covers online diagnosis and treatment for minor conditions (e.g., allergies, sinus infections, rashes) at no charge when you use **virtuwell.com** and **oncare.org**. These services are available 24/7 without an appointment. Be sure to create an account and provide your plan information before your online visit.	You pay nothing.	You pay 50% after the non-network deductible has been met.
ORTHODONTIA – CHILD		
UCare covers these services for members under age 19: Orthodontics to help restore oral structures to health and function, and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint (TMJ); and other major skeletal conditions.	You pay 30% after the in-network deductible has been met.	Not covered.
These services are not covered: • Cosmetic services, such as appliances and braces to improve the appearance of the teeth • Orthodontia services for members 19 and older		

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
OUTPATIENT FACILITY (E.G., AMBULATORY SURGERY CENTER) AND OUTPATIENT SURGERY PHYSICIAN SERVICES		
UCare covers medical and surgical services to diagnose or treat an illness or injury when delivered at an outpatient hospital, ambulatory care or surgical facility. We cover facility or hospital fees when care is provided at a hospital-based clinic. Covered outpatient services include: • Anesthesia, laboratory and diagnostic imaging services, respiratory, occupational, speech and physical therapy • Blood and blood products (unless replaced) and blood derivatives • Kidney dialysis • Drugs given during treatment • General nursing care • Other diagnostic or treatment-related outpatient services • Physician and other medical and surgical services provided while an outpatient • Radiation and chemotherapy • Use of operating rooms and other outpatient departments, rooms or facilities	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
OVARIAN CANCER SCREENINGS		
UCare covers surveillance tests for women at risk for ovarian cancer due to family history. Tests include annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound or other proven ovarian cancer screening tests currently supported by the Food and Drug Administration or National Cancer Institute.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS		
UCare covers treatment of diagnosed pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection syndrome (PANDAS) in children ages 1-18.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY		
UCare covers these physical therapy, occupational therapy and speech therapy services: 1. Rehabilitative care to correct the effects of illness or injury 2. Habilitative care and services that help a person learn or improve skills and functioning for daily living. Examples include therapy for a child not walking or talking at the expected age. We cover massage therapy when done with other treatment/methods by a physical or occupational therapist. It must be part of a prescribed treatment plan, and not billed separately. Authorization required. See the *Authorization and Notification* section in this Contract.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
These related therapy services are not covered: • Vocational rehabilitation (job training) • Educational therapy (i.e., living with a disability) • Cognitive retraining • Recreational therapy including but not limited to music therapy, art therapy, equine therapy, and yoga • Services to improve athletic ability, and braces or guards to prevent sports injuries		
PORT WINE STAIN REMOVAL SERVICES		
UCare covers port wine stain removal services.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
PREVENTIVE CARE, SCREENINGS AND IMMUNIZATIONS		
UCare covers preventive services that meet the coverage requirements under federal law. Preventive health services include screening tests (to detect conditions that have not been diagnosed and have not produced symptoms), preventive checkups and preventive counseling. Preventive benefits undergo regular federal review that may result in change. Coverage may also change for specific member ages or gender. For a complete list of covered preventive services, go to **ucare.org/preventivecare**. Preventive services include: • Items and services with an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) – Routine health exams and health assessments. A doctor or other provider will advise members on how often assessments are needed based on their age, sex and health status. – Blood pressure screening for adults – Routine cancer screenings • BRCA-related cancer risk assessment. If positive, genetic counseling and testing for women who have family members with breast, ovarian, tubal or peritoneal cancer. • Breast cancer screening (mammogram) • Cervical cancer screening • Colorectal cancer screening • Lung cancer screening in adults, ages 55-80 with a history of smoking • Prostate cancer screening (digital rectal exam only)	You pay nothing.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
– Certain routine laboratory tests, pathology and radiology (for screening purposes) • Abdominal aortic aneurysm screening in men • Abnormal blood glucose and Type 2 diabetes mellitus screening • Bacteriuria screening for pregnant women • Chlamydia and gonorrhea screening for women • Gestational diabetes screening in pregnant women with no symptoms after 24 weeks gestation • Hepatitis B screening in pregnant women or high-risk adults • Hepatitis C screening for adults ages 18-79 • HIV screening for adolescents, adults and pregnant women • Latent tuberculosis (TB) screening in adults at high risk • Osteoporosis screening for women 65 and older, and women under 65 at increased risk • RhD incompatibility screening for pregnant women • Syphilis screening for pregnant women and high-risk individuals • Universal lipids screening – Counseling/guidance/interventions to reduce risk factors • Alcohol misuse screening and behavioral counseling interventions • Depression and anxiety screening • Depression counseling for pregnant women, and women who have given birth within the past 12 months, who are at increased risk of depression • Prophylactic medication for gonorrhea in newborns	You pay nothing.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
• Healthy diet and physical activity counseling for overweight adults with other cardiovascular risk factors • Obesity screening and management • Preeclampsia screening • Sexually transmitted infections counseling • Skin cancer counseling • Tobacco cessation services and related drugs. Coverage includes at least four counseling sessions without authorization and all FDA-approved tobacco cessation drugs on the formulary. – Preventive medications (see plan formulary for limitations) • Aspirin to help prevent cardiovascular disease and colorectal cancer • Bowel preps • Low-dose aspirin for pregnant women at risk for preeclampsia • Drugs to lower risk of breast cancer • Folic acid • Drugs for HIV prevention • Oral fluoride • Statins to help prevent cardiovascular disease • Tobacco cessation products • Preventive care and screenings for women and pregnant women, based on guidelines supported by the Health Resources and Services Administration (HRSA) – Breast cancer screening (including digital breast tomosynthesis or 3D mammography) – Breastfeeding interventions, services and supplies (i.e., lactation counseling, breast pump) – Cervical cancer screening	You pay nothing.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
– Pelvic exam to screen for ovarian cancer (see the *Ovarian Cancer Screenings* section for other covered ovarian cancer screening tests) – Screening for gestational diabetes – Screening for HIV – Screening for interpersonal and domestic violence – Routine prenatal care and exams including visit-specific screening tests, education and counseling • Coverage includes one standard routine ultrasound per pregnancy – Routine postnatal care and exams. This includes health exams, assessments, education and counseling right after childbirth. – Counseling for sexually transmitted infections – Human papillomavirus (HPV) testing – Well-women visits – Screenings for diabetes mellitus after pregnancy – Depression and anxiety screening, including perinatal depression screening – Screening for urinary incontinence – Women's FDA-approved contraceptives from a pharmacy or contraception services given in a provider's office. Includes member education and counseling. Coverage is for at least one form of contraception on the plan's formulary in each of these methods: • Implantable rods • IUD with copper • IUD with progestin • Shot/injection • Oral contraceptives (combined pill) • Oral contraceptives (progestin only) • Oral contraceptives (extended/continuous use) • Patch	You pay nothing.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
• Vaginal contraceptive rings • Diaphragms • Sponges • Cervical caps • Female condoms • Spermicides • Emergency contraception (Plan B / Plan B One Step / Next Choice / Ella) • Sterilization procedures for women **Note:** Not covered in this section of the Contract are: • Hysterectomies • Anesthesia and facility services related to sterilization procedures performed during other surgical procedures, such as Cesarean section birth, gall bladder removal and abdominal hernia repair	You pay nothing.	You pay 50% after the non-network deductible has been met.
If a provider recommends a female contraception method that is not covered, prior authorization (approval in advance) is needed. The attending provider must state why the method is medically necessary. Female contraceptive methods approved for coverage via prior authorization are subject to the brand or generic drug cost share amount when obtained at an in-network pharmacy. If the drug is approved under the Copayment Review process, the drug's cost sharing amount will be $0. Call Customer Service at the phone number inside the front cover to learn more. UCare will defer to the provider's decision regarding medical necessity. Their decision may consider severity of side effects, differences in permanence and reversibility of contraceptives, and ability to properly use the item or service.		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
• Routine immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices (ACIP) **Note:** You pay nothing for flu shots in or out of network. • Preventive care for infants, children and adolescents (up to age 21) based on guidelines supported by HRSA, the American Academy of Pediatrics (AAP) and Bright Futures: – Child health supervision services including pediatric preventive services, routine immunizations, developmental assessments and laboratory services for children from birth to the end of month they turn age 21 • Measurements (blood pressure, length, height, weight, BMI, head circumference) • Sensory screenings • Routine hearing assessments and/or exams • Vision screenings. One screening is covered every calendar year. • Developmental/behavioral health screenings • Developmental screening (9, 18 and 30 months) • Autism spectrum disorder screening (18 and 24 months) • Development observation • Psychosocial/behavioral assessment • Tobacco, alcohol and drug use assessment (beginning at age 11) • Depression screening (starting at age 12) • Maternal depression screening (1, 2, 4 and 6 months). Performed at newborn screenings.	You pay nothing.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
– Procedures • Newborn blood screening including hemoglobinopathies, hypothyroidism and phenylketonuria (PKU) • Newborn bilirubin screening • Critical congenital heart defect screening • Anemia screening • Lead screening • Tuberculosis screening • Dyslipidemia screening • Hepatitis C screening beginning at age 18 • Sexually transmitted infections screening • HIV screening • Cervical dysplasia screening – Oral Health • Fluoride varnish • Fluoride supplements	You pay nothing.	You pay 50% after the non-network deductible has been met.
Call Customer Service or go to **ucare.org/preventivecare** to learn more about preventive health care and services that are USPSTF rated A or B, and services in guidelines supported by HRSA and Bright Futures. **Note: Non-preventive services (those not listed above) provided during your well visit are covered as non-preventive/diagnostic. This includes lab tests such as Thyroid Stimulating Hormone (TSH), Basic Metabolic Panel (BMP), and Complete Blood Count (CBC). If you receive preventive and non-preventive (diagnostic) health services in the same visit, the non-preventive (diagnostic) health services may require you to pay a copayment, coinsurance or deductible. The most specific and appropriate benefit in this *Benefits Chart* will apply for each service received during a visit.**		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
RECONSTRUCTIVE SURGERY		
UCare covers surgery to correct or restore a body part due to surgery, accident, injury or medical condition. This includes correcting a congenital defect, disease or anomaly resulting in a functional deficit on a covered dependent child, as determined by the attending physician. UCare covers breast reconstruction after a mastectomy, surgery and reconstruction of the other breast to produce an even appearance, including prostheses and physical complications of all stages of mastectomy and reconstructive surgery, including treatment for lymphedema.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
RETAIL CLINIC/CONVENIENCE CARE CLINIC VISITS		
UCare covers health care services provided by nurse practitioners or other eligible providers in a health care clinic located in a setting such as a retail store, grocery store or pharmacy. Services include treatment of common minor illnesses like colds, sore throats and rashes. Some services begun during a retail/convenience clinic visit may be covered under another benefit in this Contract. Examples include lab tests and x-rays. The most appropriate benefit will apply for each service received.	You pay nothing.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
SKILLED NURSING FACILITY SERVICES		
UCare covers room and board, daily skilled nursing and related services for post-acute treatment and rehabilitative care of illness or injury, after a hospital stay. Skilled nursing facility services are limited to 120 days per admission. We cover up to 120 hours of services from a private duty nurse or personal care assistant to assure proper training of hospital staff to communicate with a ventilator-dependent patient. Authorization required. See the *Authorization and Notification* section in this Contract.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Services not covered include: • Private duty nursing services, except as described above • Services and items for personal convenience		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*

Substance Use Disorder Parity and Addiction Equality Act

State and federal law requires inpatient and outpatient substance use disorder services be covered on the same basis as other medical/surgical services. This means substance abuse treatment, limits (such as prior authorization and medical necessity) and member cost-sharing can be no more restrictive than similar medical benefits. If you have questions or concerns, call Customer Service. You can also file a complaint with UCare or the Minnesota Department of Health.

SUBSTANCE USE DISORDER INPATIENT AND RESIDENTIAL SERVICE		
UCare covers the following substance use disorder treatment when medically necessary and provided in a licensed facility. • Substance use disorder assessment • Inpatient hospital treatment • Hospital-based detoxification • Residential treatment UCare authorizations or notifications may be required for select services. See the *Authorization and Notification* section in this Contract.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
SUBSTANCE USE DISORDER OUTPATIENT SERVICES, INCLUDING OFFICE VISITS		
UCare covers treatment of substance-related disorders including office visits. The most appropriate benefit will apply for each service received. We cover the following office visit and outpatient professional services to diagnose and treat substance use disorder: • Substance use disorder assessment • Individual and group treatment provided in an office setting • Medication assisted therapy • Day treatment • Intensive outpatient services We cover these services when medically necessary and provided by a licensed alcohol and drug counselor or professional working within their scope of practice. Outpatient services must be provided by a program licensed by the state in which the services are provided. **Telemedicine/Telehealth:** UCare covers interactive audio-visual visits that allow providers to evaluate, diagnose and treat you without an in-person visit. Telemedicine is often used for follow-up visits, to manage chronic conditions and medications, to consult with specialists, and other clinical services. Office visit cost-sharing applies to telemedicine/telehealth. **Note:** Telemedicine for your primary care, specialist or other provider visit is not the same as online visits using virtuwell.com and/or oncare.org. Online visits are for treating minor conditions (common cold, rashes, etc.) and appointments are not needed. See the *Online Visits (E-Visits)* section in this Contract.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
If UCare or an in-network provider determines that no structured treatment is necessary, you are entitled to a second opinion by a health care professional not affiliated with UCare who is qualified to diagnose and treat the condition. We will consider the second opinion but are not obligated to accept it. There is no cost to you for this second opinion. Authorizations or notifications may be required for select services. See the *Authorization and Notification* section in this Contract.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
TRANSPLANT SERVICES		
UCare covers eligible transplant services while you are our member. Transplants considered for coverage are limited to: • Kidney • Cornea • Heart • Lung • Liver • Intestines • Bone marrow • Stem cells • Pancreas Hospitals and providers must notify UCare before administering transplant services. See the *Authorization and Notification* section in this Contract.	You pay 30% after the in-network deductible has been met. If UCare determines that your transplant cannot be provided by an in-network provider, UCare will work with you and your care team to identify and designate an appropriate non-network provider for transplant services as described in this Contract. In-network benefits would apply for a non-network provider in this situation.	You pay 50% after the non-network deductible has been met. If UCare directs your care to a non-network provider, you pay 30% after the **in-network** deductible has been met (in-network cost-sharing levels apply).

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
Transplant services must be provided at a designated transplant center. This is any provider, group or association of health care providers chosen by UCare to provide transplant services, supplies and drugs to our members. Transplants, including multiple organs and repeat transplants of the human organs or tissue listed above are covered. This includes all related pre- and post-surgical treatment and drugs. Transplant of organs not listed above, tissue transplants or surgical implantation of mechanical devices that serve as a human organ are not covered. An exception is the surgical implantation of FDA-approved Ventricular Assist Devices (VAD) to serve as a temporary bridge to a heart transplant. Medical services received by the donor for medical and hospital expenses directly related to the organ donation are covered under the recipient's plan when the recipient is a UCare member. Treatment of medical complications that may occur to the donor are not covered under this plan. Eligible medical services related to organ donation, including evaluation, hospitalization, surgery, pre- and post-operative care are subject to the provisions, limits, maximums and other terms of this Contract.		
VISION		
UCare covers diagnosis and treatment of illness or injury to the eyes. When contacts or eyeglass lenses are prescribed for the post-operative treatment of cataracts, or for the treatment of aphakia or keratoconous, we cover the initial evaluation, lenses and fitting. Members must pay for lens replacement after the initial pair. **Note:** Vision screenings for members 21 and younger see the *Preventive Care, Screenings and Immunizations* section of the *Benefits Chart*.	For each of the first three office visits in a plan year, you pay $30. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 30% after the in-network deductible has been met. Eyewear and contact lenses: You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Vision services not covered include: • Routine screenings and eye exams for adults • Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, except as described in this Contract		

*In addition to cost-sharing, you are responsible for paying any charges from the non-network provider that exceed the allowed amount UCare pays that provider. See the *Balance Billing* section to learn more.

DESCRIPTION OF SERVICES	What you pay in-network providers	What you pay non-network providers*
X-RAYS AND IMAGING		
UCare covers x-rays and diagnostic imaging such as MRI, CT and PET scans, when medically necessary. They must be ordered by the treating provider and conducted in a clinic, outpatient or other medical facility. Some x-ray and imaging services are covered at the benefit level shown in the *Preventive Care, Screenings and Immunizations* section of this *Benefits Chart*.	You pay 30% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

Exclusions – Services Not Covered

In addition to other benefit exclusions, limits and terms in this Contract, we will not pay for the following services:

- Treatment, procedures, services and drugs that are not medically necessary and/or that are primarily educational or for the vocation, comfort, convenience, appearance or recreation of the member. This includes cognitive retraining and skills training.
- Procedures, technologies, treatments, facilities, equipment, drugs and devices that are investigative, or not clinically accepted medical services
- Professional services related to substance use disorder intervention. This is when family and/or friends gather to encourage a member to seek treatment.
- Community-based detoxification services
- Halfway houses, extended care facilities or similar facilities, foster care, adult foster care, and family child care provided or arranged by the state or county
- Services related to non-covered services, including but not limited to diagnostic tests, monitoring, laboratory services, drugs and supplies
- Elective abortion services in cases of normal pregnancy, except when the life of the mother is endangered or substantial and irreversible harm of a major bodily function would result if the fetus were carried to term; or when the pregnancy is the result of rape or incest
- Services from non-medically licensed facilities or providers, and services outside the scope of practice or license of the individual or facility providing the service
- Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or medically necessary. Examples are sports physicals, custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI), competency evaluations and adoption studies.
- Gender-confirming surgical procedures that are not medically necessary or are primarily cosmetic
- Routine foot care, except if medically necessary
- Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as required by Minnesota law. This does not apply to oral amino acid-based elemental formula if it meets our medical coverage criteria.
- Charges for sales tax
- Genetic testing when the results will not directly influence the treatment or management of the member's condition or a family planning decision
- Services provided by a family member of the enrollee, or a resident in the enrollee's home
- Services provided to a member who has other primary insurance coverage for those services and does not provide us with the information to pursue Coordination of Benefits
- The portion of a billed charge for an otherwise covered service by a non-network provider that exceeds UCare's allowed amount. We also do not cover charges or a portion of a charge that is either a duplicate charge for a service or charges for a duplicate service.
- Charges for services which would not have been made without insurance or health plan coverage, or which the member is not obligated to pay, and from providers who waive copayment, deductible and coinsurance payments by the member, except in cases of undue financial hardship
- Provider and/or member travel and related lodging, even if recommended by a doctor

- Weight loss programs and weight loss or bariatric surgeries/procedures
- Acupuncture
- Cosmetic surgery, services and treatments to improve the member's appearance or self-esteem. This exclusion does not apply to port wine stain removal and reconstructive surgery.
- Routine eye exams for adults
- Eyeglasses and contacts for members 19 and older, except as described in the *Vision* section of the *Benefits Chart*
- Routine dental care for adults
- Health club memberships (See *Health Club Savings Program* in this Contract)
- Autopsies
- Services from naturopathic providers
- Household fixtures including, but not limited to, escalators, elevators, ramps, swimming pools and saunas
- Changes to the structure of the home including, but not limited to, its wiring and plumbing or charges for installing equipment
- Vehicle, car or van changes including, but not limited to, hand brakes, hydraulic lifts and car carrier
- Equipment rented while your own equipment is being repaired by non-contracted vendors, beyond one-month rental of medically necessary equipment
- Other equipment and supplies including, but not limited to, assistive devices that we determine are not eligible for coverage
- Treatment, procedures, services and drugs provided when you are not covered under this Contract
- Medical cannabis
- Services and prescription drugs received outside the United States
- Charges for furnishing medical records or reports and related delivery charges
- Interpreter services outside of UCare

Submitting a Claim

In-network providers will submit claims to UCare on your behalf for services received while under their care. If you get a bill from an in-network provider for a covered service, submit the claim to UCare (see *How to Submit a Claim* that follows). UCare will pay in-network providers directly for covered services. You must pay any related cost-sharing.

Non-network providers may try to submit a claim to UCare on your behalf. Or you may need to send the claim directly to UCare. UCare will make payments to the non-network provider if they:

- Submit the claim on your behalf for a covered service under this Contract
- Notify UCare of signed consent by you that payment may be made directly to the provider
- Can be identified by UCare as eligible for direct payment (e.g., licensed)

If UCare cannot pay the non-network provider directly for a covered service, UCare will pay you for our share of the costs. Payment will only be made to you if you paid the provider in full, and submit an itemized bill with a paid receipt to UCare.

How to Submit a Claim

To be reimbursed by UCare for a payment, mail us a completed Member Claim Reimbursement Form. Be sure to attach copies of any bills, receipts or itemized statements from all providers. See **ucare.org** or call Customer Service to get a form.

Mail the Member Claim Reimbursement Form to:
UCare
Attention: Claims
P.O. Box 70
Minneapolis, MN 55440-0070

If you have questions about a bill you received or how to submit a claim, call Customer Service at the number inside the front cover of this Contract.

To help us process a claim:

- Submit the claim within 12 months of receiving the service. Claims received more than one year after the date of service will be denied.
- Provide details, such as copies of bills from the provider, proof of payment (if paid), and other documents needed to process the claim.

UCare will tell you the status of your claim or request more information within 90 days of receiving your claim (based on the postmark date on the claim envelope).

If your claim is denied in whole or in part, UCare will tell you why in writing. If you disagree with our decision, you may request an appeal. See the *Appeals and Complaints* section of this Contract for how to request an appeal.

You should keep copies of all itemized receipts and correspondence for your records.

Paying Claims During the Grace Period

If you receive Advanced Premium Tax Credit (APTC) through MNsure, and you fail to pay your premium (after paying at least one month's premium), UCare must provide a three-month grace period before ending coverage.

During the first month of the grace period, UCare must pay claims for covered services received. If you do not pay the unpaid premium amount in full within the second or third month of the grace period, UCare will pend or hold those claims. If premiums are paid in full within the three-month grace period, the pended or held claims will be processed as covered benefits. If you fail to pay the unpaid premium in full before the end of the three-month grace period, your coverage will end on the last day of the first month. Claims incurred during month two and month three will be denied. You must pay the full cost of services for those months.

If you do not receive APTC, UCare has a 31-day grace period during which claims are paid for covered services. If you fail to pay the unpaid premium in full before the end of the 31-day grace period, coverage will end on the last day of the month that was paid in full. UCare will seek to recover payments from you for claims incurred and paid on your behalf during the grace period. You must pay the full cost of services received during the grace period.

Coordination of Benefits

When COB Applies

1. Coordination of benefits (COB) applies to this plan when you have health care coverage under more than one plan.
2. If you have other coverage in addition to this plan, your coverage under this plan is determined by the *Order of Benefit Determination Rules* (described below). Under these rules, the benefits of this plan:
   a. Shall not be reduced when this plan determines its benefits before another plan; but

b. May be reduced when another plan determines its benefits first. This reduction is described in *Effect on the Benefits of this Plan*, below.

Please note: "Plan" refers to any of the following that provides benefits or services for, or because of, medical or dental care/treatment:

- Group insurance or group-type coverage, whether insured or uninsured, or individual coverage. This includes prepayment, group practice or individual practice coverage.

  It also includes coverage other than school accident-type coverage.

- Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs of the United States Social Security Act, as amended from time to time).

  Each Contract for coverage is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two parts, each of the parts is a separate plan.

Order of Benefit Determination Rules

1. **General**. When there is a basis for a claim under this plan and another plan, this plan is a secondary plan that has its benefits determined after those of the other plan, unless:
   a. The other plan has rules coordinating its benefits with the rules of this plan; and
   b. Both the other plan's rules and this plan's rules in section 2. below, require that this plan's benefits be determined before those of the other plan.
2. **Rules**. This plan determines its order of benefits using the first of the following rules that apply:
   a. **Nondependent/dependent.** The benefits of the plan that covers the person as a member (other than as a dependent) are determined before those of the plan that covers the person as a dependent.
   b. **Dependent child/parents not separated or divorced.** Except as stated in 2.c. below, when this plan and another plan cover the same child as a dependent of different persons, called *parents:*
      i. The benefits of the plan of the parent whose birthday is earlier in a year are determined before those of the plan of the parent whose birthday is later in that year; but
      ii. If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter time.

      However, if the other plan does not have the rule above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

   c. **Dependent child/separated or divorced parents.** If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      i. First, the plan of the parent with custody of the child;
      ii. Then, the plan of the spouse of the parent with the custody of the child; and
      iii. Finally, the plan of the parent not having custody of the child.

      However, if the terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply to any claim determination period or plan year during which any benefits are paid or provided before the entity has that knowledge.

   d. **Joint custody.** If the terms of a court decree state that the parents shall share joint custody, without stating that one of the

parents is responsible for the health care expenses of the child, the plan(s) providing coverage will follow the *Order of Benefit Determination Rules* outlined in 2.c. above.

e. **Active/inactive employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

f. **Workers' compensation.** Coverage under any workers' compensation act or similar law applies first. You should submit claims for expenses incurred as a result of an on-duty injury to the employer before submitting them to UCare.

g. **No-fault automobile insurance.** Coverage under the No-Fault Automobile Insurance Act or similar law applies first.

h. **Longer/shorter length of coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member or enrollee longer are determined before those of the plan that covered the person for a shorter time.

Effect on the Benefits of this Plan

1. **When this section applies.** This section applies when, according to the *Order of Benefit Determination Rules* section above, this plan is a secondary plan to one or more other plans. In that event, the benefits of this plan may be reduced. Such other plan or plans are referred to as *the other plans* in section 2 below.
2. **Reduction in this plan's benefits.** The benefits of this plan will be reduced when the sum of:
   a. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
   b. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

For non-emergency services from a non-network provider, and determined to be non-network benefits, the following reduction of benefits apply:

When the plan is a secondary plan, this plan will pay the remainder of any eligible expenses, according to the non-network benefits described in this Contract. Most non-network benefits are covered at 50% of the non-network provider reimbursement amount, after you pay the deductible. In no event will this plan provide duplicate coverage.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply COB rules. UCare has the right to decide which facts are needed. UCare may get needed facts from, or give them to any other organization or person. UCare need not inform, nor get the consent of, any person to obtain information. Unless federal or state law prevents disclosing the information without the consent of the patient or the patient's representative, each person claiming benefits under this plan must provide UCare with any facts needed to process the claim.

Facility of Payment

A payment made by another plan may include an amount that should have been paid by this plan. If it does, UCare may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan.

UCare will not have to pay that amount again. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

If we pay more than we should have paid under this COB provision, UCare may recover the excess from one or more of the following:

1. The persons we have paid or for whom we have paid
2. Insurance companies or
3. Other organizations

See the *Right of Recovery* section below to learn more.

Right of Recovery

This section describes UCare's right of recovery. It includes rights to reimbursement and subrogation. Subrogation is when UCare pays a claim for an injury or illness that was caused by a third party, and then tries to recover that amount from the third party. UCare's rights are subject to Minnesota and federal law. To learn how these laws affect UCare's subrogation rights, contact an attorney.

UCare has a right of recovery against any third party, person, corporation, insurer or other entity that may be legally responsible to pay medical expenses related to your illness or injury. Our right of recovery is based on this section. UCare's right to recover its subrogation interest applies only after you have received a full recovery for your illness or injury from another source of payment.

UCare's subrogation interest is the reasonable cash value of any benefits you received.

UCare's right to recover its subrogation interest may require UCare to pay a pro-rated share of your disbursements, attorney fees and costs, and other expenses incurred in obtaining a recovery from another source, unless UCare is separately represented by an attorney. In that case, an agreement regarding allocation may be reached. If an agreement cannot be reached, the matter must go to binding arbitration.

By accepting coverage under this Contract, you agree:

1. If UCare pays benefits for medical expenses you incur due to any act by a third party for which the third party is, or may be liable, and you obtain full recovery, you must reimburse UCare for the benefits paid, according to Minnesota law.
2. To cooperate with UCare or its designee to help protect UCare's legal rights under this subrogation provision, and to provide all information UCare may request to determine its rights under this provision.
3. To provide prompt written notice to UCare when you make a claim against a party for injuries.
4. To do nothing to decrease UCare's rights under this provision, either before or after receiving benefits, or under the Contract.
5. UCare may take action to preserve its legal rights. This includes bringing suit in your name.
6. UCare may collect its subrogation interest from the proceeds of any settlement or judgment recovered by you, your legal representative or legal representative(s) of your estate or next-of-kin.

Coverage Decisions

At any time, you or your provider can contact Customer Service to ask about your benefits, or request a coverage decision on what is covered by this plan. If you disagree with this coverage decision, you can file an appeal.

To File an Appeal

You may direct any appeal question to UCare Customer Service by calling us at the phone number on the inside front cover of this Contract. You can also mail your appeal to us at:

UCare
Attn: Appeals and Grievances
P.O. Box 52
Minneapolis, MN 55440-0052

You have a right to an external review at any time and you are not required to go through UCare's internal appeal process. UCare has a process to resolve appeals. Appeals may be filed by you or your named representative. This person may be a relative, friend, advocate, doctor, attorney or anyone acting on your behalf. Filing an appeal may require us to review your medical records to resolve your appeal. You may review the information relied upon in the course of the appeal, and present evidence and testimony as necessary. You are allowed continued coverage pending the outcome of your appeal.

If your oral or written appeal does not require a medical determination and we cannot resolve your complaint within 10 days, we will tell you within 10 calendar days that we received your appeal. We will tell you our decision within 30 calendar days of receiving your appeal.

If your oral or written appeal is about an initial UCare coverage decision, and it requires a medical determination to resolve, your appeal must be made to us within 180 days of our initial coverage decision.

We will notify you within 10 calendar days that we received your appeal. We will tell you our decision within 15 calendar days of receiving your pre-service appeal or 30 calendar days after receiving your post-service appeal. In addition:

- We will provide written notice of our appeal review decision to you and your provider, when applicable. For pre-service appeals only, we may take up to 4 more days to make a medical determination due to circumstances beyond our control. If we take more than 15 days to make a decision, we will tell you the reason for the extension. Post-service disputes will be resolved within 30 calendar days of receiving your appeal.
- When an initial decision by UCare not to grant an authorization request is made before or during an ongoing service requiring our authorization, and your attending provider believes that UCare's decision warrants an expedited appeal, you or your attending provider may request an expedited review by telephone.
- If our appeal review decision upholds our initial decision, you may request an external review. You may also request an external review prior to our decision if we waive the internal review process, we fail to comply with any of our review requirements including, but not limited to time limits, or you applied for an expedited external review at the same time you qualify for and applied for an expedited internal review as explained below.
- If our appeal review decision is partially or wholly adverse to you, we will tell you of your right to submit a request for an external review. We will tell you how to begin the external review process.

Expedited Review

If your attending provider determines the need for an expedited review, you or your provider can request an expedited review by telephone. If we conclude that a delay could seriously harm your life, health or ability to regain full function, we will process your appeal as an expedited review. We will then tell you and your provider by telephone of our decision no later than 72 hours after receiving the request.

External Review of an Adverse Decision

If you are not satisfied with UCare's review decision, you may request an external review through the State of Minnesota by contacting the Minnesota Department of Health.

- Your request for an external review should be sent in writing
- You must request an external review within six months from the date of an adverse decision
- You can request an external review while your internal UCare appeal is underway
- Your request must be accompanied by a filing fee, that will be refunded if the adverse decision is completely reversed. Filing fees will not exceed $75 during a plan year.

Contact information for filing your appeal with the State of Minnesota:

Minnesota Department of Health
Managed Care Systems Section
P.O. Box 64882
St. Paul, MN 55164-0882
651-201-5100 or 1-800-657-3916 toll free

Independent Review of an Adverse Non-formulary Drug Coverage Decision

If UCare denies coverage for a drug not on our formulary, you may request an external exception review by an independent review organization. UCare contracts with an independent review organization on behalf of our members.

For expedited independent review requests, we will tell you and your provider of the decision within 24 hours of receiving the request. For standard independent review requests, we will tell you and your provider of the decision within 72 hours of receiving the request. Please note, submitting a request for independent review does not prevent you from requesting a review using all other appeal rights described in this section. You can use any appeal right at any time during the appeal process.

You may direct independent review questions about non-formulary drugs to UCare Customer Service. The phone number is inside the front cover of this Contract and on your member ID card. If you do not want to call, or you called and were not satisfied, you can submit your independent review request in writing. Call Customer Service if you need help submitting your independent review request in writing.

Email us at **cag@ucare.org** or mail your written request to us at:

UCare
Attn: Appeals and Grievances
P.O. Box 52
Minneapolis, MN 55440-0052

Complaints

If you have a complaint that is not related to a coverage decision or appeal, contact us by phone or in writing.

- Complaints must be made within 180 calendar days after the problem you are contacting us about.
- If you call us with a complaint, we will tell you within 10 calendar days of our decision. If we do not tell you within 10 calendar days, you may file a written complaint.
- For written complaints, we will tell you within 10 calendar days that we received your written complaint. Within 30 calendar days we will send you a written response of our findings or decisions. If we need more information due to circumstances beyond our control, it may take up to 14 more calendar days to respond to your complaint. We will notify you in advance of the extension and tell you the reasons for the extension.

To issue a complaint, call Customer Service at one of the numbers inside the front cover of this Contract. We will tell you if more action is needed. We may be able to give you an answer right away. If we need more information or time, we will tell you.

If you do not want to call, or you called and were not satisfied, you can submit your complaint in writing. If you need help submitting a written complaint, call Customer Service.

Email us at **cag@ucare.org** or mail your written complaint to:

UCare
Attn: Appeals and Grievances
P.O. Box 52
Minneapolis, MN 55440-0052

You can deliver your written complaint to UCare offices at:

500 Stinson Blvd. NE
Minneapolis, MN 55440-0052

At any time during the complaint or appeals process, you also have the right to file a complaint with the Minnesota Department of Health at 1-800-657-3916, or the Minnesota Department of Commerce at 1-800-657-3602.

Eligibility and Enrollment

Eligibility

This Contract covers individuals and dependents who have enrolled in plan coverage. Eligibility is determined by MNsure.

Members enrolled in this plan must be a resident of Minnesota and a US citizen, national or non-citizen who is lawfully present.

Individuals currently enrolled in Medicare Part A and/or Part B are not eligible to enroll in this plan.

Individuals currently enrolled in government programs may not be eligible to enroll in this plan.

Individuals currently in jail or prison are not eligible to enroll in this plan. If a person covered under this plan goes to jail or prison, coverage may end. See the *Ending Coverage* section.

If you become eligible for and/or enroll in Medicare, we cannot use this as a reason for nonrenewal or ending coverage. You should call MNsure and request to disenroll from this plan.

Service Area

To be eligible for this Contract you must live in the geographic service area covered by this Contract when you enroll. Moving outside this plan's service area may make you ineligible for coverage. Examples of a move that would make you ineligible would be permanently moving outside of Minnesota or moving more than 60 miles outside the service area covered by this Contract.

Dependents

Dependents eligible for coverage are individuals for whom the member requests coverage including:

- Legally married spouse
- Dependent children up to age 26 including:
  - Natural-born children
  - Step-children
  - Legally adopted children
  - Children for whom you or your covered spouse are legal guardians, including foster children
  - Dependent children of domestic partner of unmarried member meeting domestic partnership requirements. See the *Definitions* section for requirements.
  - Other children including grandchildren who have always lived with you since birth and are financial dependents of you or your covered spouse; and children required to be covered by reason of a Qualified Medical Child Support Order
- Disabled children who have reached age 26 while under this Contract if: the child is both incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability, and dependent upon the member for support and maintenance

- Domestic partners of unmarried members. For purposes of this Contract, includes both same sex and opposite sex domestic partners. See the *Definitions* section for requirements.

Effective Date of Coverage

All coverage under this Policy begins and ends at 12:01 am Central Time on the date the coverage becomes effective. Coverage begins on the date as stated at the time of enrollment. Monthly premiums must be paid in full by the due date.

Changing Your Coverage

You must enroll in a plan during the annual open enrollment period, unless you experience a qualifying life event during the plan year. Qualifying life events allow members or dependents to make changes to their existing coverage or enroll in a different plan during a special enrollment period. You must report the qualifying life event to MNsure within 60 days, except as noted, and select a plan during the special enrollment period. Below are qualifying life events that must be reported:

- Gain or become a dependent due to marriage
- Gain a dependent due to birth, adoption, placement for adoption, foster care or child support order. This event can be reported after the 60-day period, but the premium must be paid to begin coverage if you select coverage back to the date of birth, adoption, placement for adoption, foster care or child support order.
- Loss of dependent(s) due to death, divorce or legal separation
- Gain citizenship, national or lawfully present status
- Loss of existing minimum essential coverage. This includes losing employer-based coverage, losing coverage due to divorce or family changes, COBRA coverage ends, age off parent's plan by turning age 26, and losing eligibility for Medicaid or other government-sponsored coverage. It does not include voluntary terminations or loss of coverage due to not paying premiums.
- Circumstances that cause a change to or new eligibility for Advanced Premium Tax Credit or Cost Sharing Reduction
- Gain access to an individual coverage HRA (health reimbursement arrangement) or are provided a qualified small employer HRA
- Is a victim of domestic abuse or spousal abandonment as defined by Federal law, and is enrolled in minimum essential coverage
- Enrollment or non-enrollment was unplanned, accidental or due to error, misrepresentation or inaction by MNsure or U.S. Department of Health and Human Services
- Current Qualified Health Plan issuer violates material provision of the Contract

Other life events that may qualify you for special enrollment may be accepted by MNsure. Visit mnsure.org to learn more, including when coverage would begin and what is needed to verify a qualifying life event.

Renewing Coverage

During the annual open enrollment period, you can continue with your current plan or change plans for the upcoming year.

Premiums

UCare offers several ways to pay your monthly premium. You must pay your premium in full by the 1st of the month of the coverage month.

Your payment options are:

- Automatic withdrawal from a checking or savings account: Complete and return the Automatic Payment Form found at **ucare.org/for-members**. Automatic withdrawal will occur between the 1st and 5th of the coverage month.
- Online bill pay/Direct pay from your bank: This option is done through your bank. Contact your bank to learn more. Make sure your payment is addressed to UCare, PO Box 856532, Minneapolis, MN 55485-6532.

- Pay online using a VISA or MasterCard debit or credit card: Log in to your secure member account on **ucare.org** and follow the instructions.
- Check or money order mailed to: UCare, PO Box 856532, Minneapolis, MN 55485-6532.

Note: Please allow three to five business days for your payment to be applied to your account once we receive it.

Any changes to premium rates will be made as allowed by state and federal laws.

Grace Period

This Contract remains in force if you pay the premiums in full at any time during the grace period. If premiums are not paid in full during the grace period, coverage will end. If you receive Advanced Premium Tax Credits (APTC) and have paid at least one full month's premium, the grace period is three months. If you do not receive APTC, the grace period is 31 days from your premium due date. See the *Ending Coverage* section below to learn more.

Ending Coverage

If You Want to Leave this Plan – Contact MNsure

If you choose to leave this plan, you must contact MNsure at least one month before you want your coverage to end. Your request can be verbal or in writing. MNsure's phone number is 651-539-2099 or 1-855-366-7873.

Reasons why you may want to end your coverage include, but are not limited to:

- You are enrolling in Medicare or a UCare Medicare Advantage plan
- You obtained health insurance through an employer
- You recently got married and have coverage through your spouse
- You are eligible for Medical Assistance

Note: Once you end coverage through MNsure, you cannot re-enroll until the next annual open enrollment period (unless you qualify for a special enrollment period).

When Coverage Ends

Unless otherwise stated in this Contract, coverage ends when the earliest of the following occurs:

1. You request MNsure to end coverage in writing and provide notice that you obtained other minimum essential coverage. In this case, the last day of coverage under this Contract will be:
   a. The last day of the month, stated by you, if you provide at least 14 days notice;
   b. Fourteen (14) days after the end of coverage is requested, if the notice above is not supplied;
   c. On a date determined by UCare, if we are able to end coverage in fewer than 14 days and you request an earlier end date; or
   d. The last day before your Medical Assistance, MinnesotaCare or Children's Health Insurance Program (CHIP) coverage begins, if you become eligible for these programs.
2. You choose another plan during the annual open enrollment period or any special enrollment period. The last day of coverage will be the last day of the month before your new coverage begins.
3. You are no longer eligible for coverage (example: you move out of Minnesota or outside the geographic service area of this Contract). The last day of coverage in this case will be the last day of the month following the month in which the notice is sent to you, unless you request an earlier end date.
4. You fail to pay monthly premiums for coverage on time and the grace period has run out.

   If you receive Advanced Premium Tax Credits (APTC) and have paid at least one full month's premium, you have a three-month grace period. Failure to pay premiums in full during the grace

period will end your plan coverage. The last day of coverage will be the last day of the first month of the three-month grace period. See *Paying Claims During the Grace Period* to learn how failure to pay premiums can affect your cost for services.

If you do not receive APTC subsidies, the grace period is 31 days from your premium due date, or as required by Minnesota law. Coverage will end on the last day of the last month for which premium payment was received by UCare. See *Paying Claims During the Grace Period* to learn how failure to pay premiums can affect your cost for services.

At the time we end your coverage, you may still owe us for premiums not paid. In the future, if you want to enroll again in one of our plans, you will have to pay for any unpaid premiums in the past 12 months from your prior UCare enrollment.

5. You cancel this Contract within the first 10 days of receiving it. Coverage will end retroactive to the Contract effective date.
6. You perform an act, practice or omission that represents fraud, or knowingly misrepresent a material fact with regard to this Contract. Fraud includes, but is not limited to:
   a. Knowingly giving UCare false information
   b. Allowing the use of your member ID card by any unauthorized person
   c. Using another person's member ID card
   d. Submitting fraudulent claims
   e. Engaging in fraudulent activity related to eligibility for coverage under this Contract

   In this event, coverage ends on the date stated by UCare in written notice to you that coverage ended due to fraud or intentional misrepresentation of a material fact. Coverage may be retroactively ended at UCare's discretion to the original date of coverage or the date the fraudulent act took place. UCare will give you at least 30 days advance written notice of any decision under this section.
7. The last day of the month when UCare notifies you that UCare will cease doing business or will discontinue a particular product under Minnesota law. This includes refusal to renew all of UCare's existing individual health plans and cancellation of all outstanding individual health plan contracts.

UCare will make reasonable accommodations for all members with disabilities (as defined by the Americans with Disabilities Act) before ending their coverage.

If You Change UCare Plans During the Year

Different UCare plans have different deductibles and out-of-pocket limits. If you move from one plan to another during the year, your deductible and out-of-pocket limit may restart at zero. That means the amounts you already paid may not count toward the new limits. This does not happen if you move between different levels of cost-sharing reduction plans, or from a cost-sharing reduction plan to a standard Silver plan.

If MNsure determines that you should receive a higher or lower level of cost-sharing due to a change in your income, any amount you already paid toward your deductible and out-of-pocket limit will carry over to your new plan.

Harmful Use of Services

If UCare determines you are receiving health services or prescription drugs in a quantity or manner that may harm your health, we may require you to select a single in-network doctor, a hospital and a pharmacy to be your coordinating health care providers. We will tell you if we intend to require this change.

You will have 30 days to choose an in-network doctor, a hospital and a pharmacy to serve as your coordinating health care providers. If you do not choose providers to coordinate your care within 30 days, we will select them for you. Your in-network benefit coverage may be restricted to those services provided by, or arranged through, your coordinating health care providers. You have the right to appeal this restriction.

If you fail to use those selected providers for non-emergency services, you may be denied coverage. If you need care or services from a provider other than your coordinating health care providers, we may require a referral from your coordinating health care provider.

This does not apply to emergency care.

Important Notice from UCare About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UCare and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **UCare has determined that the prescription drug coverage offered by UCare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current UCare coverage will not be affected. Please contact Customer Service at the telephone number listed inside the front cover.

If you do decide to join a Medicare drug plan and drop your current UCare coverage, be aware that you will not and your dependents may be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with UCare and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Customer Service at the telephone number listed inside the front cover.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through UCare changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

Visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Entire Contract and Changes

This Contract, including any endorsements and attached papers, is the entire Contract of insurance. No amendment or change to this Contract will be valid until approved by an executive officer of UCare. This approval must be included in, or attached to this Contract. No agent may change this Contract or waive any of this Contract's provisions.

When UCare approves a change in this Contract, you will receive a new Contract or amendment. No other person or entity may make changes or amendments to this Contract. All amendments must be in writing.

Acceptance of Coverage in this Contract

By accepting the health services coverage described in this Contract, you allow use of a Social Security number for identity purposes. You also agree that the information you provided in the application and as part of the enrollment process is accurate and complete. You understand and agree that any incorrect or incomplete statements made as part of application and enrollment under this Contract may make this Contract invalid.

Clerical Error

A clerical error will not deprive you of coverage nor create a right to benefits not covered under this Contract. However, you will not be eligible for coverage beyond the scheduled end of your coverage because of a failure to record the termination.

Access to Records and Confidentiality

UCare complies with all state and federal laws regulating confidentiality and use of protected health information. We receive information about you as part of our work in providing health plan services and coverage, and in operating our health plan. We use your information for health care operations, including but not limited to: coordination of care, preventive health, case management programs, coordination of benefits, enrollment and eligibility status, benefits management, utilization management, premium billing, claims issues, and coverage decisions. Other uses include customer service activities, complaints and appeals, health promotion, quality activities, health survey information, actuarial studies, premium rating, legal and regulatory compliance, risk management, professional peer review, credentialing, accreditation, anti-fraud activities, as well as business planning and administration. UCare's full privacy notice follows this section in this Contract, and is also at **ucare.org**.

Relationship Between Parties

The relationships between UCare and in-network providers are contractual relationships between independent contractors. In-network providers are not agents or employees of UCare. Relationships between providers and members are that of health care provider and patient. The provider is solely responsible for health care provided to any member.

Assignment

UCare has the right to assign any and all of its rights and responsibilities under this Contract to any subsidiary or affiliate of UCare or to any other appropriate organization or entity.

Notice

Except as otherwise stated in this Contract, written notice given by UCare is considered notice to all affected in administering this Contract in the event of termination or nonrenewal of this Contract. However, notice of termination for not paying premiums shall be given by UCare to the member.

Discretionary Authority

Subject to state and federal law, UCare has discretion to interpret and construe all of the terms and conditions of this Contract, and make determinations regarding benefits and coverage.

Misstatement Time Limit

Your eligibility for this Contract is based on the statements you provided in your application. If your application contained misstatements or false information, we may deny payment for services or cancel your coverage.

After two years from the date of issue of this Contract, no misstatements made on your application, except those made in fraud, may be used to void this Contract or to deny a claim for a service that occurs after the two-year period.

Notice of Privacy Practices

Effective Date: July 1, 2013

This Notice describes how medical information about you* may be used and disclosed and how you can get access to this information. Please review it carefully.

*In this Notice, "you" means the member and "we" means UCare.

Questions

If you have questions or want to file a complaint, you may contact our Privacy Officer at UCare, Attn: Privacy Officer, P.O. Box 52, Minneapolis, MN 55440-0052. You may also file a complaint with the Secretary of the U.S. Department of Health & Human Services at the Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. We will not retaliate against you for filing a complaint.

Why are we telling you this?

UCare believes it is important to keep your health information private. In fact, the law requires us to do so. The law also requires us to tell you about our legal duties and privacy practices. We are required to follow the terms of the Notice currently in effect.

What do we mean by "information?"

In this Notice, when we talk about "information," "medical information," or "health information," we mean information about you that we collect in our business of providing health coverage for you and your family. It is information that identifies you.

What kinds of information do we use?

We receive information about you as part of our work in providing health plan services and health coverage. This information includes your name, address, and date of birth, gender, telephone numbers, family information, financial information, health records, or other health information. Examples of the kinds of information we collect include: information from enrollment applications, claims, provider information, and customer satisfaction or health surveys; information you give us when you call us about a question or when you file a complaint or appeal; information we need to answer your question or decide your appeal; and information you provide us to help us obtain payment for premiums.

What do we do with this information?

We use your information to provide health plan services to members and to operate our health plan. These routine uses involve coordination of care, preventive health, and case management programs. For example, we may use your information to talk with your doctor to coordinate a referral to a specialist.

We also use your information for coordination of benefits, enrollment and eligibility status, benefits management, utilization management, premium billing, claims issues, and coverage decisions. For example, we may use your information to pay your health care claims.

Other uses include customer service activities, complaints or appeals, health promotion, quality activities, health survey information, underwriting, actuarial studies, premium rating, legal and regulatory compliance, risk management, professional peer review, credentialing, accreditation, antifraud activities, as well as business planning and administration. For example, we may use your information to make a decision regarding an appeal filed by you.

In addition, we may use your information to provide you with appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We may also share information with family members

or others you identify as involved with your care, or with the sponsor of a group health plan, as applicable.

We do not use or disclose any genetic information for the purpose of underwriting.

We do not sell or rent your information to anyone. We will not use or disclose your information for fundraising without your permission. We will only use or disclose your information for marketing purposes with your authorization. We treat information about former members with the same protection as current members.

Who sees your information?

UCare employees see your information only if necessary to do their jobs. We have procedures and systems to keep personal information secure from people who do not have a right to see it. We may share the information with providers and other companies or persons working with or for us. We have contracts with those companies or persons. In those contracts, we require that they agree to keep your information confidential. This includes our lawyers, accountants, auditors, third party administrators, insurance agents or brokers, information systems companies, marketing companies, disease management companies, or consultants.

We also may share your information as required or permitted by law. Information may be shared with government agencies and their contractors as part of regulatory reports, audits, encounter reports, mandatory reporting such as child abuse, neglect, or domestic violence; or in response to a court or administrative order, subpoena, or discovery request. We may share information with health oversight agencies for licensure, inspections, disciplinary actions, audits, investigations, government program eligibility, government program standards compliance, and for certain civil rights enforcement actions. We also may share information for research, for law enforcement purposes, with coroners to permit identification or determine cause of death, or with funeral directors to allow them to carry out their duties. We may be required to share information with the Secretary of the Department of Health and Human Services to investigate our compliance efforts. There may be other situations when the law requires or permits us to share information.

We only share your psychotherapy notes with your authorization and in certain other limited circumstances.

Other uses and disclosures not described above will be made only with your written permission. We will also accept the permission of a person with authority to represent you.

In most situations, permissions to represent you may be cancelled at any time. However, the cancellation will not apply to uses or disclosures we made before we received your cancellation. Also, once we have permission to release your information, we cannot promise that the person who receives the information will not share it.

What are your rights?

You have the right to ask that we don't use or share your information in a certain way. Please note that while we will try to honor your request, we are not required to agree to your request.

You have the right to ask us to send information to you at an address you choose or to request that we communicate with you in a certain way. For example, you may request that your mailings be sent to a work address rather than your home address. We may ask that you make your request in writing.

You have the right to look at or get a copy of certain information we have about you. This information includes records we use to make decisions about health coverage, such as payment, enrollment, case, or medical management records. We may ask you to make your request in writing. We may also ask you to provide information we need to answer your request. We have the right to charge a reasonable fee for the cost of making and mailing the copies. In some cases, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will tell you in writing. We may give you a right to have the decision reviewed. Please let us know if you have any questions about this.

You have the right to ask us to correct or add missing information about you that we have in our records. Your request needs to be in writing. In some cases, we may deny a request if the information is correct and complete, if we did not create it, if we cannot share it, or if it is not part of our records. All denials will be in writing. You may file a written statement of disagreement with us. We have the right to disagree with that statement. Even if we deny your request to change or add to your information, you still have the right to have your written request, our written denial, and your statement of disagreement included with your information.

You have the right to receive a listing of the times when we have shared your information in some cases. Please note that we are not required to provide you with a listing of information shared prior to April 14, 2003; information shared or used for treatment, payment, and health care operations purposes; information shared with you or someone else as a result of your permission; information that is shared as a result of an allowed use or disclosure; or information shared for national security or intelligence purposes. All requests for this list must be in writing. We will need you to provide us specific information so we can answer your request. If you request this list more than once in a 12-month period, we may charge you a reasonable fee. If you have questions about this, please contact us at the address provided at the end of this Notice.

You have the right to receive notifications of breaches of your unsecured protected health information.

You have the right to receive a copy of this Notice from us upon request. This Notice took effect July 1, 2013.

How do we protect your information?

UCare protects all forms of your information, written, electronic and oral. We follow the state and federal laws related to the security and confidentiality of your information. We have many safety procedures in place that physically, electronically and administratively protect your information against loss, destruction or misuse. These procedures include computer safeguards, secured files and buildings and restriction on who may access your information.

What else do you need to know?

We may change our privacy policy from time to time. As the law requires, we will send you our Notice if you ask us for it. If you have questions about this Notice, please call UCare Customer Service at the toll-free number on the back of your member ID card. This information is also available in other forms to people with disabilities. Please ask us for that information.

Definitions

Admission: The medically necessary admission to an inpatient facility for the acute care of illness or injury.

Advanced Premium Tax Credit (APTC): Under the Affordable Care Act, you may be eligible for a tax credit to reduce the cost of your premiums. Individuals and families may be eligible if they have household incomes less than 400% of the federal poverty level, are not eligible for Medical Assistance programs, and purchase health insurance through a health insurance exchange. For more information and to learn if you are eligible, visit mnsure.org.

Allowed Amount: The maximum amount UCare will pay a provider for a covered service. This may also be called "eligible expense," "payment allowance," or "negotiated rate." If your non-network provider charges more than the allowed amount, you may have to pay the difference. (See the *Balance Billing* and *How UCare Pays Providers* sections.)

Appeal: A request for UCare to review a coverage decision or a grievance again.

Approved Clinical Trial: An approved phase I, phase II, phase III or phase IV clinical trial conducted to prevent, detect or treat cancer or a life-threatening condition and is not designed solely to test toxicity or disease pathophysiology. To be an approved clinical trial, it must be: (i) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; (ii) exempt from obtaining an investigational new drug application; or (iii) approved or funded by certain government entities and their partners, or nongovernment entities operating under government guidelines. To learn if a clinical trial is an approved clinical trial, call Customer Service.

Authorization: A decision by UCare that a covered health care service, prescription drug or durable medical equipment is medically necessary. Some services are covered only if your provider gets authorization (approval) from us before you receive the services, except in an emergency. Other services require your provider to obtain authorization after a certain point in your therapy to continue. Authorization is not a promise that your plan will cover the cost.

Balance Billing: When a non-network provider bills you for the difference between their charge and UCare's allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. This may be in addition to any cost-sharing amounts owed. An in-network provider may **not** balance bill you for covered services. See the *Balance Billing* section for details.

Benefits: The health services and supplies (described in this Contract) approved by us for coverage. See the *Benefits Chart* in this Contract for descriptions of covered benefits.

Calendar Year: The 12-month period beginning 12:01 am on January 1, and ending 12:00 am on the following January 1.

Claim: An invoice, bill or itemized statement that details the items and services a provider delivered to a member.

Coinsurance: Your share of the costs of a covered health care service. Coinsurance is calculated as a percent (for example, 30%) of the allowed amount for the service. You pay coinsurance **plus** any deductibles you owe. For example, if the plan's allowed amount for an office visit is $100 and you have met your deductible, your 30% coinsurance payment would be $30. In-network coinsurance usually costs you less than non-network coinsurance.

Continuity of Care: The arrangement for ongoing and uninterrupted services for members in the event of without-cause contract termination between UCare and a provider who is, at the time the contract ends, providing care to members.

Contract: Our agreement with you on the benefits and coverage under this plan.

Convenience Care Clinic: A clinic in a retail setting that offers a limited set of services and does not require an appointment.

Copayment: A fixed amount (for example, $60) you pay for a covered health care service, usually when you receive the item or service. The amount can vary by the type of service. In-network copayments usually are less than non-network copayments. Copayments do not apply to your deductible. They do apply to your out-of-pocket limit.

When you receive health services from an in-network provider and a copayment applies, you pay the lesser of the charge billed for the benefit (i.e., amount allowed) or your copayment. The copayment may not exceed the amount billed by the provider for the benefit or the cost of the prescription drug.

Cosmetic Surgery: Surgery to improve or change appearance (other than reconstructive surgery) that is not medically necessary to treat a related illness or injury.

Cost-Sharing: Your share of costs for covered services that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Examples of cost-sharing are copayments, coinsurance and deductibles. Other costs, including your premiums and the cost of care a plan doesn't cover usually aren't considered cost-sharing.

Coverage Decision: A decision UCare makes about whether a service is covered and the amount we will pay for covered services or items, based on your benefits.

Covered Service: A health service or supply that is eligible for benefits when performed and billed by an eligible provider, as described in this Contract.

Deductible: The amount you have to pay for covered health care services before your plan begins to pay. For example, if your deductible is $1,000, you are responsible for 100% of the cost until your $1,000 deductible is met. Any amount above $1,000 is subject to coinsurance until your out-of-pocket limit is met. The deductible may not apply to all services.

Dependent: See *Eligible Dependent*.

Diagnostic Health Services: These services evaluate symptoms, diagnose a suspected illness, monitor a diagnosed condition and guide treatment of a condition or symptom. A certain test that is listed in this document as a preventive service may be regarded as preventive in one context and diagnostic in another. For example, a blood test to monitor or guide treatment for a condition that has already been diagnosed is considered diagnostic. Deductibles, copayments or coinsurance for diagnostic health services are applied as stated in each plan's benefits.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches and blood testing strips for people with diabetes.

Eligible Dependent: Dependents eligible for enrollment in this plan include:

- Spouse: Member's current legal spouse.
- Child: (i) Member's natural or legally adopted child; (ii) child for whom the member or member's spouse is legal guardian; (iii) step-child of member who is child of member's spouse; or (iv) dependent child of domestic partner of unmarried member meeting requirements in final bullet below. Child must be under age 26 or disabled.
- Qualified grandchild: Member's unmarried grandchild, who lives with and is financially dependent upon the grandparent covered by this Contract. The grandchild must be younger than age 26 or disabled.
- Disabled dependent: Member's dependent child or grandchild as included above, who is age 26 or older and physically handicapped or mentally disabled, and who is dependent upon the member for the majority of her/his financial support. Disability must have been present before age 26. Pregnancy is not a disability.
- Domestic partner of unmarried member, includes either same sex or opposite sex partner, if they:
  - Share the same permanent residence
  - Are jointly responsible for basic living expenses
  - Are not married to anyone and are each other's sole domestic partner with the intent to remain together indefinitely

- Are each 18 years of age or older
- Are not related by blood closer than permitted under the state marriage laws where you reside
- Are each mentally competent to consent to a contract; and
- Have completed a domestic partnership affidavit form and agreed to the conditions of that form

Embedded Deductible and Out-of-Pocket Limit: If you have a family plan, it has an embedded deductible and out-of-pocket limit. If you or a family member reaches the individual deductible/ out-of-pocket limit, coverage will begin even if your overall family deductible/out-of-pocket limit is not met. Any amount paid toward an individual's deductible/out-of-pocket limit also applies toward the family's deductible/out-of-pocket limit. Once the family deductible/out-of-pocket limit is met, the plan covers charges for any family member.

For example, your family deductible is $2,000 and the individual deductible is $1,000. If your spouse has $1,000 in medical bills, his or her deductible is met even though the family deductible may not have been met at that time. After the individual deductible is met, UCare will help pay that member's future covered expenses.

Emergency Medical Condition: An illness, injury, symptom or condition so serious, including severe pain, that a reasonable person would seek care right away to avoid severe harm, and seek treatment to stop the illness, injury, symptom or condition from getting worse.

Emergency Services: Evaluation and treatment of an emergency medical condition.

Emergency Transportation: Air or ground ambulance services for an emergency medical condition.

Enrollee: The person who applied for coverage and enrolled in this plan. The enrollee and his or her enrolled dependents are our members.

Exclusions: Health care services or items that your plan does not pay for or cover.

Facility: A licensed medical center, clinic, hospital, skilled nursing care facility or outpatient care facility, lawfully providing a medical service according to government licensing privileges and limitations.

Formulary: The list of generic and brand drugs that are covered by this plan.

Grace Period: The time period allowed by state and federal law that states how long coverage will continue if premiums are not paid. See the *Grace Period* section for details.

Grievance: A complaint that you make to your plan.

Habilitative Care: Health care services for conditions that have significantly limited the successful initiation of normal speech or motor development. Examples include therapy for a child who is not walking or talking at the expected age. Services may include physical and occupational therapy, and speech-language therapy in inpatient and/or outpatient settings.

Health Care Provider: Any licensed physician or non-physician (excluding naturopathic providers), lawfully performing a medical service according to government licensing privileges and limitations, who provides direct patient care to members covered in this Contract.

Hospice Services: Services to provide comfort and support for people in last stages of a terminal illness, and their families.

Hospital: A licensed facility, lawfully providing medical services according to government licensing privileges and limitations, and that is recognized by UCare as an appropriate facility. A hospital is not a nursing home or convalescent facility.

Hospital-Based Billing: Also called provider-based billing, is a billing practice where patients may receive two charges on their bill for services provided in a hospital-based clinic. One charge is for the facility or hospital fee, and one charge is for the professional services or physician fee.

Hospital-Based Clinic: A clinic owned and operated by a hospital. It is common for large, integrated health care systems to own and operate hospital-based clinics.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually an overnight stay. An overnight stay for observation may be considered outpatient care.

HSA-Compatible High Deductible Health Plan: A plan that meets federal requirements allowing a member to contribute to a health savings account (HSA).

In-Network Provider: Physicians, other health care professionals, medical groups, hospitals, other facilities and pharmacies that have a contract with UCare to deliver health care services. See *Using Your Plan's Network*.

Inpatient: A medically necessary stay for acute care of illness or injury, other than in a hospital's outpatient department, where a charge for room and board is made by the hospital or skilled nursing facility.

Investigative: A drug, device, diagnostic procedure, technology or medical treatment or procedure is investigative if reliable evidence does not allow conclusions about its safety, effectiveness or effect on health outcomes. We base our decision after examining the following reliable evidence, none of which is conclusive in and of itself:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the drug or device is furnished; and
2. The drug, device, diagnostic procedure, technology or medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials; and
3. Medically reasonable conclusions about its safety, effectiveness or effect on health outcomes have not been established.

Medicaid or Medical Assistance: A joint federal-state program that helps pay medical costs for some people with low incomes and limited resources.

Medical Necessity or Medically Necessary: Health care services suitable in terms of type, frequency, level, setting and duration, to the member's diagnosis or condition, and testing and preventive services. Medically necessary care is (1) consistent with accepted practices by providers in the same or similar specialty to manage the condition, procedure or treatment at issue; and (2) help restore or maintain the member's health; or (3) prevent worsening of the member's condition; or (4) prevent the likely onset of a health problem or detect an early problem.

Member: Individuals eligible for and enrolled in this plan, including the enrollee and dependents.

Mental/Behavioral Health Professional: A psychiatrist, psychologist or mental health therapist licensed to provide mental health or substance use services to our members.

Network: The facilities, providers and suppliers your health plan has a contract with to provide health care and dental services to members.

Network Provider: See *In-Network Provider*.

Non-Network Provider: A provider who does not have a contract with us or your plan to provide services to you. You will usually pay more to see a non-network provider. Check your Contract to learn how to identify this plan's network providers.

Notification: A UCare requirement that your provider notify us within a stated time after a service requiring notification occurs.

Out-of-Pocket Limit: The most you pay during a Contract period (usually one year) before your health insurance or plan begins to pay 100% of the allowed amount for covered services. This dollar limit applies to services with in-network providers and does not include (i) premiums, (ii) health care services this plan does not cover, and (iii) cost-sharing for services from non-network providers. There is no out-of-pocket limit for services with non-network providers.

Outpatient: Medically necessary diagnosis, treatment, services or supplies provided by a hospital's outpatient department or a licensed surgical center and other ambulatory care facility (other than in a doctor's office).

Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Palliative Care: Special care to relieve suffering and improve quality of life for people with serious, chronic and life-threatening illnesses. Palliative care focuses on providing relief from symptoms, pain and stress from a serious illness.

Physician: A licensed medical doctor or doctor of osteopathy, lawfully performing medical services, according to government licensing privileges and limitations, who delivers medical or surgical care to members covered by this Contract

Physician Services: Health care services provided or coordinated by a licensed medical physician (M.D. – Medical Doctor, or D.O. – Doctor of Osteopathic Medicine).

Plan: The benefits or health care services and items covered under this Contract.

Premium: The amount that must be paid for your health insurance or plan.

Prescription Drugs: Drugs that by law, require a prescription.

Preventive Health Services: Preventive health services include screening tests (to detect conditions that have not been diagnosed and have not produced symptoms), checkups, and preventive counseling. Routine preventive health services are generally covered without cost-sharing (deductibles, copayments, or coinsurance) as required by the Affordable Care Act and other regulation. Age range and frequency for screening tests may vary based on an individual's risk factors.

Primary Care Provider: A doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: Any licensed physician or non-physician (excluding naturopathic providers), lawfully performing medical services according to government licensing privileges and limitations, who provides direct patient care to members covered by this Contract.

Qualified Health Plan (QHP): An insurance plan that is certified by MNsure.

Reconstructive Surgery: Surgery and follow-up treatment to correct or improve a part of the body due to birth defects, accidents, injuries or medical conditions or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

Rehabilitative Care: Health care services that help a person keep, get back or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language therapy and psychiatric rehabilitation services in inpatient and/or outpatient settings.

Retail Clinic: A clinic in a retail setting that offers a limited set of services and does not need an appointment.

Service Area: Geographic area where this plan accepts members. The plan may disenroll you if you move out of its service area.

Skilled Nursing Care: Services from licensed nurses in your home or in a nursing home.

Skilled Nursing Facility: A licensed facility, lawfully performing medical services according to government licensing privileges and limitations, and recognized by UCare as an appropriate facility to deliver inpatient post-acute hospital and rehabilitative care and services to our members. This does not include facilities that primarily treat mental or substance use health.

Specialist: A doctor who focuses on a specific area of medicine or type of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Telemedicine: Interactive audio-visual visits that allow health care providers to evaluate, diagnose and

treat patients at a distance. It uses electronic communications and software to provide clinical services without an in-person office visit. Telemedicine is often used for follow-up visits, to manage chronic conditions and medications, to consult with specialists, and other clinical services.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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