2022 Summary of Benefits

EssentiaCare Comparison Guide

EssentiaCare

Essentia Health + UCare

your shopping checklist

- [ ] enroll in Original Medicare
- [ ] select the plan that fits my lifestyle
- [ ] enroll in an EssentiaCare Medicare Advantage plan

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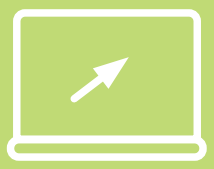
3 ways to enroll



online

ucare.org/medicare123

fast and easy

secure data transfer

save enrollment to finish at later time

by mail

fill out the enrollment form and mail in the postage-paid envelope

phone

call 1-877-671-1061 to enroll with a licensed Medicare Sales Specialist

call a trusted broker near you

Why EssentiaCare?

Medicare can feel overwhelming when you're trying to figure it out on your own. Our team of de-complicators can help simplify.

We're the figure-outers who can tell you what you need to know about Medicare and help you pick a plan that's right for you.

UCare and Essentia Health formed a special partnership to offer EssentiaCare, a network-based Medicare Advantage plan.

Two names you know and trust bringing you a fresh approach on a Medicare Advantage plan. With EssentiaCare, you pay less for care when you use in-network providers.

Get the peace of mind you deserve with UCare's broad coverage and affordable prices, and Essentia Health's expertise in providing high-quality, safe and cost-effective care.

access to

Essentia Health
doctors, specialists and advanced practitioners

+

Mayo Clinic
in Rochester

the ABC&D of Medicare

Confused about Medicare? Our team of de-complicators is at your service to answer all your questions. We help you navigate so you can choose the health plan that's right for you.

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. Some services require preauthorization. To get a complete list of services we cover, call us and ask for the Evidence of Coverage.

This information is not a complete description of benefits. Call 1-877-671-1061 or TTY users call 1-800-688-2534 for more information. Limitations, copays and restrictions apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat EssentiaCare members, except in emergency situations. Please call Customer Service or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

EssentiaCare is a PPO plan with a Medicare contract. Enrollment in EssentiaCare depends on contract renewal. EssentiaCare is a registered trademark of Essentia Health non-profit corporation.

If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare & You handbook. View online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users call 1-877-486-2048.

Understanding the four parts of Medicare

Original Medicare is made up of two parts – **Part A** and **Part B**

Part A – hospital coverage

Medicare Part A helps pay for inpatient hospital and skilled nursing facility stays, hospice care and home health care.

Part B – medical coverage

Medicare Part B helps pay for a wide range of medical expenses including doctor visits, many preventive screenings, lab tests, X-rays, outpatient procedures, mental health services, durable medical equipment and more.

Additional coverage and services
eyewear, hearing aids, dental, health & wellness

Medicare Advantage plan

Part C – Medicare Advantage plan

Think of Part C (Medicare Advantage plan) as a package.

It combines Part A with Part B, then may add special benefits that Medicare does not cover, such as vision and dental care. Many packages even include Part D prescription drug coverage.

Discover the all-in-one convenience of a Medicare Advantage plan. Get all your health benefits in one package and find peace of mind in protecting your health and managing your out-of-pocket costs.

Part D – outpatient prescription drug coverage

Part D is available to anyone enrolled in either Medicare Part A or Part B. Part D can be purchased through two types of health plans: Medicare Advantage plans that include Part D or stand-alone prescription drug plans.

You must choose whether or not to enroll in Part D when you first become eligible for Medicare. Keep in mind that if you decline it, but decide you want this coverage later, you may have to pay a penalty.

Most Part D plans have a monthly premium, and benefits and drug costs that vary by plan. Each health plan publishes a list of covered drugs called a formulary.

When am I eligible for Original Medicare?

You qualify for Medicare if you:

- Are 65 or older or meet special criteria
- Worked for at least 10 years and paid Medicare taxes (or your spouse did)
- Are a citizen and permanent resident of the United States

How do I enroll in Original Medicare?

You may apply online at **ssa.gov/medicare,** via telephone appointment at 1-800-772-1213 (TTY users call 1-800-325-0778), or in person at a local Social Security office.

When can I enroll in a Medicare Advantage plan?

Medicare has limits to when and how often you can change your Medicare Advantage plan. These specific time frames, called "election periods," determine when you can enroll in, or voluntarily disenroll from, a Medicare Advantage plan.

Initial Coverage Election Period (ICEP)

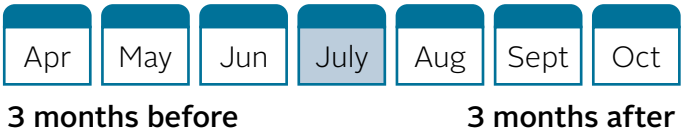
When you become eligible for Medicare (either by age or disability), you may enroll in Original Medicare and a Medicare Advantage plan during your Initial Coverage Election Period (ICEP). When you enroll during the ICEP, the soonest Medicare allows us to accept your enrollment application is three months before you become eligible.

If you have had Part A and are just applying for Part B, the ICEP is limited to the three months prior to your enrollment in Part B.

Enroll when first eligible

You have a seven-month period (three months before you turn 65, the month you turn 65, and three months after your birthday month).

Example
birthday is July 4



Late enrollment penalties

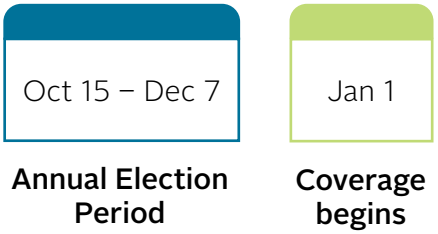
If you don't sign up for Part B and Part D when you first become eligible, Medicare may apply a penalty if you decide to sign up later. You'll pay the penalty for as long as you have Part B and Part D coverage. Some exceptions apply.

When can I make changes to my Medicare plan coverage?

Annual Election Period (AEP)

Every year between October 15 and December 7, you can make a plan change to be effective on January 1 of the following year. This change may include adding or dropping Medicare Part D.

Note: Medicare Advantage plans release their rates and benefits for the following year on October 1.



Special Enrollment Periods (SEPs)

You may qualify for a Special Enrollment Period at any point during the year if you:

- Are leaving or losing coverage through an employer or union (including COBRA)
- Move to an area where your plan isn't offered
- Are on Medical Assistance or no longer qualify for Medical Assistance
- Receive Extra Help for Medicare Part D
- Are losing your current coverage or your plan is no longer offered

Medicare Advantage Open Enrollment Period (MA-OEP)

During the MA-OEP, Medicare Advantage members may enroll in another Medicare Advantage plan or disenroll from their Medicare Advantage plan and return to Original Medicare (limited to one change). This period runs from January 1 through March 31 or if you are newly enrolled in Medicare, within your first three months of enrollment.

Why choose Medicare Advantage?

EssentiaCare Medicare Advantage plans offer all-in-one convenience, with medical and Medicare Part D prescription drug coverage in one simple plan. Plus, extras like eyewear, hearing aids, dental and fitness benefits. EssentiaCare plans protect your health and your wallet, limiting your out-of-pocket costs each year.

Get the benefits and coverage you need

Network — Essentia Health's integrated care system provides high-quality, safe and cost-effective care. Other providers are available in our network.

Choice — range of plans and premiums to fit your needs, lifestyle and budget

Customer service — local and easy to reach

Convenience — medical and Medicare Part D prescription drug coverage in one plan

Lots of extras — eyewear, hearing aids, dental and fitness benefits

Online care — convenient e-visits with your provider through Essentia MyChart

prescription drug coverage

dental coverage

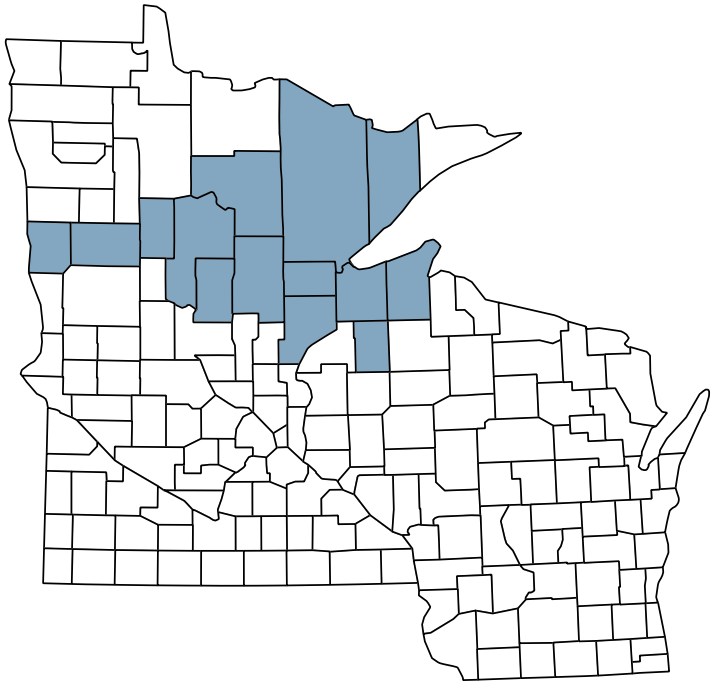
over-the-counter allowance

coverage when traveling

fitness options

eyewear and hearing aids

Plans and coverage where you live



To be eligible for EssentiaCare you must live in one of the following counties:

Minnesota counties
Aitkin, Becker, Carlton, Cass, Clay, Crow Wing, Hubbard, Itasca, Lake, Pine, St. Louis

Wisconsin counties
Bayfield, Douglas, Washburn

Plan options:

EssentiaCare Access (PPO)*
EssentiaCare Access is only available in St. Louis (MN), Bayfield (WI), Douglas (WI) and Washburn (WI) counties.

EssentiaCare Secure (PPO)*

EssentiaCare Grand (PPO)*

For information about plans available in other counties, please call us at 1-877-671-1061, TTY users call 1-800-688-2534, 8 am – 8 pm, seven days a week (Oct. 1 – March 31), 8 am – 8 pm, Monday – Friday (April 1 – Sept. 30)

You can see any provider that accepts Medicare, but you'll pay less when you get care from more than 2,100 Essentia Health providers

Essentia Health is an integrated health system that combines the strengths and talents of doctors, specialists and advanced practitioners, to serve patients and communities.

To look up a doctor, go to **ucare.org/medicare123** and click on "find a doc, find a drug" and choose "EssentiaCare" under "Pick your plan."

*PPO — Preferred Provider Organization

Picture yourself in one of our plans

Mark

Mark turns 65 next month. He's active, in great health and wants good coverage in case of an emergency or serious illness. He is willing to pay higher cost-sharing in exchange for a $0 premium with EssentiaCare Access.

John

John is in good health and doesn't foresee any large health care expenses. He takes prescription drugs to manage his health. EssentiaCare Secure is a great fit, providing all-in-one coverage for a low premium.

June

June has chronic health issues and relies on her care providers at Essentia Health to monitor and treat her condition. She also wants the confidence of knowing she has broad coverage if she needs it. EssentiaCare Grand gives June peace of mind.

	Access	Secure	Grand
Plan Premium (you must continue to pay your Part B premium)	$0	$35	$109
Medical and hospital	✓	✓	✓
Fitness programs	✓	✓	✓
Dental	✓	✓	✓
Eyewear and hearing aids	✓	✓	✓
Over-the-counter allowance	✓	✓	✓
Medicare Part D prescription drug coverage	✓	✓	✓
Coverage when traveling	✓	✓	✓
Maximum out-of-pocket (in-network)	$6,500	$4,500	$3,500

Fitness options

One Pass fitness program

NEW for 2022

One Pass is a fitness program for your body and mind, available to you at no additional cost. You'll have access to more than 20,000 participating fitness locations nationwide.

One Pass includes:

- More than 20,000 on-demand and live-streaming fitness classes
- Workout builders to create your own workouts
- A Home Fitness Kit available to members who are physically unable to visit or who reside at least 15 miles outside a participating fitness location
- Personalized, online brain training program to help improve memory, attention and focus
- Nearly 30,000 social activities, community classes, and events available for online or in-person participation

Health Club Savings

Join a class, work with weights, swim some laps, or try something new. Health Club Savings offers the variety you want and the flexibility you deserve. If you belong to a participating health club that is not in the One Pass network, you can receive a reimbursement of up to $30 in your monthly health club membership fees.

How it works

Bring your EssentiaCare member ID card to your health club to sign up. To see a full list of participating health clubs, visit **ucare.org/healthwellness.**

Prescription drug coverage

Refer to the chart on page 23 for more information on these benefits.

Find a drug

Search our List of Covered Drugs (formulary) at **ucare.org/medicare123,** by clicking on "Learn more" under "Find a doctor or drug" and opening the Drug List tab.

If you prefer, use the printed 2022 List of Covered Drugs provided. Check the alphabetical index in the back to find your drugs.

Find a pharmacy

Fill your prescriptions at one of more than 23,000 preferred and 41,000 standard pharmacies in our plan network.

You'll save more when you use preferred pharmacies:

- Preferred retail pharmacies include Essentia Health, Coborn's, Costco, Cub Foods, CVS/Target, Hy-Vee and Sam's Club/Walmart
- Express Scripts preferred mail order pharmacy provides a 90-day supply for two copays.

You can also fill your prescriptions at standard cost-share pharmacies nationwide, including Walgreens.

To find a preferred pharmacy in our plan network, use the online search tool at **ucare.org/medicare123.**

If you prefer, call for help or request a Provider and Pharmacy Directory at 1-877-671-1061.

Members who take select formulary insulins have a low copay of $30 to $35 for a one-month supply, regardless of Part D coverage phase. This is only available to members not participating in the Extra Help program.

Over-the-counter allowance

Refer to the chart on page 21 for more information on these benefits.

Our plans help you save money in lots of ways, including an over-the-counter (OTC) allowance through Healthy Savings.® This allowance is loaded onto your Healthy Savings card on Jan. 1 and July 1. The allowance is yours to spend as you like on qualifying health items including cough drops, first aid supplies, pain relief, sinus medication and toothpaste at participating stores. Find participating locations, browse eligible items, and learn more at **healthysavings.com/ucare**.

Use your Healthy Savings OTC allowance at participating stores, including:

- Walmart
- Cub
- Coborn's
- Hornbachers
- Hy-Vee
- Kowalski's
- Lunds & Byerlys
- Super One Foods

Eyewear

Refer to the chart on page 20 for more information on these benefits.

Our plans offer a vision benefit with a dollar allowance for glasses and contact lenses. These allowances range from $100 to $200, depending on the plan you choose. Members can choose to visit any provider they want for their eyewear.

Hearing aids

Refer to the chart on page 19 for more information on these benefits.

Plans include coverage for routine hearing tests and diagnostic hearing exams. Members of EssentiaCare Grand also receive an annual allowance to use toward the purchase of hearing aids.

Dental coverage

Refer to the chart on page 19 for more information on these benefits.

All plans include dental coverage, and some give you the flexibility to purchase optional dental coverage. You can make the most of your dental benefits when you see providers in the Delta Dental National Medicare Advantage network. You may pay more for services if you see a provider outside this network.

To find a dentist in the network, go to **deltadentalmn.org/find-a-dentist** and select "I want to see if a dentist is in-network" or "I'm looking for a new dentist" if you don't have one.

UCare Reward Benefit Mastercard

The UCare Reward Benefit Mastercard is a reloadable card that features:

NEW for 2022

- Flexibility, choice and ease of use
- Access to your preloaded annual eyewear allowance
- Additional rewards you can earn and spend as you choose

Community education discount

Get up to a $15 discount on most Minnesota community education classes. Check your local community education catalog or contact the local school district for class times and locations. Limit of three discounts in a calendar year (one discount per class enrollment).

Care by phone or online

Refer to the chart on page 18 for more information on these benefits.

Telehealth visits are covered for Medicare-approved services. E-visits (online evaluation and diagnosis) are covered for some conditions.

Enrollment

Choose a clinic

Select a primary care clinic from the Primary Care Clinic Listing found in your plan information kit. Within this clinic, you may see any doctor. You may see any specialist in our network without a referral.

Forms by mail

We must receive your enrollment application by (not postmarked by) the end of the month prior to when you want coverage to start (except during the Annual Election Period — must be received by 12/7 for a 1/1 effective date).

Once we receive your enrollment application, you:

- may receive a call from us if any required information is missing from the enrollment form
- get a letter within 15 days to verify your enrollment
- may receive a letter from us if you did not have a Medicare Part D plan from the date you were first eligible
- may receive a letter from us if you are leaving an employer group plan to join our plan
- will get a new member packet
- will get a EssentiaCare member identification card that you can begin using on your effective date

Should you require medical services or prescription drugs before you receive your ID card, please call Customer Service at 1-855-432-7025 (TTY users call 1-800-688-2534).

How to pay your premiums

You can choose to pay your monthly premium:

- by check
- automatic payment/Electronic Funds Transfer (EFT)
- Social Security or Railroad Retirement Board withdrawal
- online at **member.ucare.org**

Please do not send payment with your enrollment form.

3 ways to enroll

online

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fast and easy

secure data transfer

save enrollment to finish at later time

by mail

fill out the enrollment form and mail in the postage-paid envelope

phone

call 1-877-671-1061 to enroll with a licensed Medicare Sales Specialist

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Plan benefit details

TABLE OF CONTENTS

	Access	Secure	Grand
2022 monthly plan premium (you must continue to pay your Medicare Part B premium)	$0	$35	$109
Medical deductible	$0	$0	$0
Medicare Part D deductible	Tier 1 = $0 Tiers 2–5 = $480	Tiers 1 & 2 = $0 Tiers 3–5 = $400	Tiers 1 & 2 = $0 Tiers 3–5 = $250
Maximum out-of-pocket The most you will pay out-of-pocket for in-network Medicare-covered services each year. Excludes Medicare Part D and all other non-Medicare covered services and premium.	**In-network** $6,500; then 100% covered **Out-of-network combined with in-network** $6,500; then 100% covered	**In-network** $4,500; then 100% covered **Out-of-network combined with in-network** $10,000; then 100% covered	**In-network** $3,500; then 100% covered **Out-of-network combined with in-network** $7,000; then 100% covered
Hospital Care			
Inpatient hospital care (per admission)	$300 copay per **day** (days 1–5), then 100% covered	$300 copay per **day** (days 1–5), then 100% covered	$250 copay per **stay** (not per day), then 100% covered
Outpatient hospital or procedure	$395 copay	$350 copay	$300 copay
Ambulatory surgery center	$395 copay	$350 copay	$300 copay
Doctor Visits — in person or telehealth for Medicare-approved services			
Primary	$22 copay	$0 copay	$0 copay
Specialist	$50 copay	$45 copay	$30 copay
E-visits through Essentia MyChart	$0 copay	$0 copay	$0 copay
Preventive Care			
Routine physical exam	$0 copay	$0 copay	$0 copay
"Welcome to Medicare" preventive visit (if in the first 12 months on Part B)	$0 copay	$0 copay	$0 copay
Annual Wellness Exam (if you've had Part B for more than 12 months)	$0 copay	$0 copay	$0 copay
Flu and pneumonia vaccines (shingles vaccine is covered under Medicare Part D)	$0 copay	$0 copay	$0 copay
Mammogram screening, prostate cancer screening exam, bone mass measurement, diabetes screening, preventive colorectal cancer screening	$0 copay	$0 copay	$0 copay

In general, out-of-network cost-sharing in the U.S. is 40%; cost-sharing is the same both in- and out-of-network for some services.

	Access	Secure	Grand
Emergency / Urgent Care — network does not apply			
Emergency care	$90 copay	$90 copay	$90 copay
Urgently needed services	$45 copay	$45 copay	$45 copay
Diagnostic Tests, Radiation Therapy, X-rays and Lab Services			
Diagnostic tests (e.g., MRI and CT scans), radiation therapy and X-rays	20% coinsurance	10% coinsurance up to a maximum of $150 per day	10% coinsurance up to a maximum of $50 per day
Lab services (e.g., Protime INR, cholesterol)	**In-network** $0 copay **Out-of-network** $0 copay	**In-network** $0 copay **Out-of-network** $0 copay	**In-network** $0 copay **Out-of-network** $0 copay
Hearing Services			
Diagnostic hearing exam	$50 copay	$45 copay	$35 copay
Routine hearing exam	$0 copay	$0 copay	$0 copay
Annual allowance for hearing aids	Not covered	Not covered	**In-network** $500 **Out-of-network** the plan will pay 50% coinsurance up to a maximum of $500; you pay 50% coinsurance of the total cost plus any amount above the plan maximum
Dental Coverage			
Coverage includes	$250 yearly allowance	Routine dental with optional coverage available	Routine dental with optional coverage available
Premium	$0	**+ $25** per month	**+ $25** per month
Deductible	$0	$75 per year	$75 per year
Annual plan maximum	$250	$2,000	$2,000
Oral examinations	Covered up to $250 allowance limit	One per year* (two total with purchase of optional coverage)	One per year* (two total with purchase of optional coverage)

*These services are included without purchase of optional coverage and no deductible applies. These services do not apply to annual plan maximum.

For dental limitations and exclusions, see pages 26–27.

Members must be enrolled in plan for 24 consecutive months before coverage applies to bridges, dentures, prosthetics and implants.

	Access	Secure	Grand
Routine cleanings	Covered up to $250 allowance limit	One per year* (two total with purchase of optional coverage)	One per year* (two total with purchase of optional coverage)
X-rays		Annual bitewing* (full mouth every 5 years with purchase of optional coverage)	Annual bitewing* (full mouth every 5 years with purchase of optional coverage)
Fluoride treatment		Covered*	Covered*
Periodontal maintenance cleanings		One per year* (more with purchase of optional coverage)	One per year* (more with purchase of optional coverage)
Basic restorative services (e.g., fillings, root canals, periodontal services)		30% coinsurance with purchase of optional coverage	30% coinsurance with purchase of optional coverage
Major restorative procedures (e.g., crowns, bridges, implants, dentures)		60% coinsurance with purchase of optional coverage	60% coinsurance with purchase of optional coverage
Vision services			
Diagnostic eye exam	$35 copay	$45 copay	$35 copay
Annual routine eye exam	$0 copay	$0 copay	$0 copay
Eyeglasses or contact lenses after cataract surgery	20% coinsurance	$0 copay	$0 copay
Annual allowance for eyeglasses or contacts at any provider	$100	$100	$200
Mental Health Services			
Inpatient hospital stay (90-day limit per stay) Limited to 190 days in a lifetime in a psychiatric hospital	$300 copay per **day** (days 1–5); then 100% covered	$300 copay per **day** (days 1–5); then 100% covered	$250 copay per **stay** (not per day); then 100% covered
Outpatient mental health care	$40 copay	$40 copay	$30 copay
Skilled Nursing Facility Care (or swing bed)^			
Care in a skilled nursing facility with **no prior 3-day hospital stay required**	$0 copay per day for days 1–20; $188 copay per day for days 21–100; per benefit period	$0 copay per day for days 1–20; $188 copay per day for days 21–100; per benefit period	$0 copay per day for days 1–20; $125 copay per day for days 21–100; per benefit period

*These services are included without purchase of optional coverage and no deductible applies. These services do not apply to annual plan maximum.

For dental limitations and exclusions, see pages 26–27.

	Access	Secure	Grand
Other Services			
Physical therapy	$40 copay	$40 copay	$30 copay
Ambulance (within the U.S. and its territories) Includes air and/or ground	$400 copay	$375 copay	$300 copay
Transportation (non-emergency)	Not covered	Not covered	Not covered
Medicare Part B Drugs^ Generally, drugs that must be administered by a health professional	20% coinsurance	20% coinsurance	20% coinsurance
Chiropractic services through ChiroCare network^ Manual manipulation of the spine to correct subluxation	$20 copay	$20 copay	$15 copay
Acupuncture All plans cover acupuncture for chronic low back pain, based on Medicare criteria	Doctor visit copays apply (see page 18)	Doctor visit copays apply (see page 18)	Doctor visit copays apply (see page 18)
Podiatry services	$50 copay	$45 copay	$30 copay
Over-the-counter (OTC) allowance	$50 twice a year	$50 twice a year	$50 twice a year
Durable medical equipment^ (e.g., oxygen equipment, CPAP)	20% coinsurance	20% coinsurance	20% coinsurance
Prosthetic devices (e.g., braces, colostomy bags and supplies)	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic supplies • Continuous blood glucose monitors • Other glucose monitors • Test strips, and lancets • Inserts and shoes (Insulin and syringes covered under Medicare Part D)	 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance	 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance	 20% coinsurance $0 copay $0 copay $0 copay

^Service requires prior authorization

	Access	Secure	Grand
Coverage when traveling			
EssentiaCare plans include out-of-network coverage. You also have access to online care for $0 anytime and anywhere with Essentia MyChart.			
Within the U.S.			
Care from any out-of-network provider that accepts Medicare	40% of the cost of services	40% of the cost of services	40% of the cost of services
Emergency care	$90 copay	$90 copay	$90 copay
Urgently needed services	$45 copay	$45 copay	$45 copay
Ambulance (within the U.S. and its territories) Includes air and/or ground	$400 copay	$375 copay	$300 copay
Worldwide Emergency Care (outside the U.S. and its territories)			
Emergency care including post-stabilization	$90 copay	$90 copay	$90 copay
Ground ambulance to the nearest hospital for emergency care	$90 copay	$90 copay	$90 copay

Note: Only emergency coverage is worldwide. You may want to consider purchasing a separate travel policy while traveling outside the U.S. for services such as air ambulance.

Our plans that include Part D cover your Part D vaccines. You'll have the lowest copay (Tier 1) for the two-dose shingles vaccine (SHINGRIX®) at any in-network pharmacy.

Preferred Pharmacies

More savings — Pay less for your drugs at more than 23,000 pharmacies, including Essentia Health, Coborn's, Costco, Cub Foods, CVS/Target, Hy-Vee and Sam's Club/Walmart

Standard Pharmacies

More choice — Fill your prescriptions at more than 41,000 standard cost-share pharmacies nationwide, including Walgreen's

To find a preferred pharmacy in your plan network, use the online search tool at **ucare.org/medicare123.**

If you prefer, call for help or request a Provider and Pharmacy Directory at **1-877-671-1061.**

	Access	Secure	Grand
Medicare Part D Coverage — included with these plan options at no additional premium			
Cost Sharing for Deductible: You pay the full cost of your drugs until you reach this amount	Tier 1 = $0 Tiers 2–5 = $480	Tiers 1 & 2 = $0 Tiers 3–5 = $400	Tiers 1 & 2 = $0 Tiers 3–5 = $250
Initial Coverage Phase: From $0 to $4,430 in annual prescription drug costs. After you meet the deductible, you pay the amounts listed below			
Cost Sharing (Retail): Our network includes preferred pharmacies, which offer lower cost sharing than standard network pharmacies.			
Tier 1 Preferred generic drugs	**Retail** — 30-day supply Preferred: $3 copay Standard: $12 copay	**Retail** — 30-day supply Preferred: $1 copay Standard: $10 copay	**Retail** — 30-day supply Preferred: $1 copay Standard: $10 copay
Tier 2 Generic drugs	**Retail** — 30-day supply Preferred: $10 copay Standard: $20 copay	**Retail** — 30-day supply Preferred: $10 copay Standard: $20 copay	**Retail** — 30-day supply Preferred: $7 copay Standard: $17 copay
Tier 3 Preferred brand drugs	**Retail** — 30-day supply Preferred: 17% coinsurance Standard: 25% coinsurance	**Retail** — 30-day supply Preferred: $47 copay Standard: $47 copay	**Retail** — 30-day supply Preferred: $35 copay Standard: $45 copay
Tier 4 Non-preferred drugs	**Retail** — 30-day supply Preferred: 50% coinsurance Standard: 50% coinsurance	**Retail** — 30-day supply Preferred: 50% coinsurance Standard: 50% coinsurance	**Retail** — 30-day supply Preferred: 50% coinsurance Standard: 50% coinsurance
Tier 5 Specialty drugs	**Retail** — 30-day supply Preferred: 25% coinsurance Standard: 25% coinsurance	**Retail** — 30-day supply Preferred: 25% coinsurance Standard: 25% coinsurance	**Retail** — 30-day supply Preferred: 28% coinsurance Standard: 28% coinsurance

	Access	Secure	Grand
Coverage Gap			
Once you have reached $4,430 in annual prescription drug spending (your cost plus EssentiaCare's cost), you pay as shown	25% of the cost of generic and brand drugs	25% of the cost of generic and brand drugs	25% of the cost of generic and brand drugs
Catastrophic Coverage			
Once you have reached $7,050 in annual prescription drug spending (excluding EssentiaCare's cost), you pay as shown	**You pay** The greater of $3.95 or 5% coinsurance for generic drugs The greater of $9.85 or 5% coinsurance for all other drugs	**You pay** The greater of $3.95 or 5% coinsurance for generic drugs The greater of $9.85 or 5% coinsurance for all other drugs	**You pay** The greater of $3.95 or 5% coinsurance for generic drugs The greater of $9.85 or 5% coinsurance for all other drugs

Cost-sharing may differ based on pharmacy type or status (mail-order, retail, long-term care (LTC), home infusion), whether the pharmacy is in our preferred or standard network or whether the prescription is a 30-, 60-, or 90-day supply.

Additional requirements or limits on covered drugs — Some covered drugs may have additional requirements or limits on coverage. These may include: Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST). Visit **ucare.org/medicare123** to find out if your drug has any additional requirements or limits. You can also ask us to make an exception to these restrictions or limits. Details on how to make these requests are in the formulary and in the EssentiaCare Evidence of Coverage.

Extra Help for Medicare Part D

You may be able to get Extra Help to help pay for your prescription drug premium and costs.

To see if you qualify, call:

- 1-800-MEDICARE (TTY users call 1-877-486-2048), 24/7
- Social Security Administration at 1-800-772-1213 (TTY users call 1-800-325-0778), 7 am – 7 pm, Monday – Friday
- Your State Medicaid Office or County Human Services Office
- Senior LinkAge Line® at 1-800-333-2433

Some people will pay a higher premium for Part D coverage because their yearly income is over certain amounts.

Additional information

Provider network coverage

As a member of our plan, you can receive your care from either a network provider or an out-of-network provider. If you use an out-of-network provider, your share of the costs for your covered services may be higher. Please note that if you receive care from an out-of-network provider, they must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare.

Out-of-network/non-contracted providers are under no obligation to treat EssentiaCare members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Learn about special services

Care Management

EssentiaCare provides extra support to members with short-term or complex health needs, and social service needs. A case manager is available to you based on such factors as your use of acute services, your health assessment or provider referral.

We offer care management to members with select diagnoses who transition to home from a hospital or skilled nursing facility. Care management may entail communication with a facility discharge planner, medication reconciliation, assistance with scheduling follow-up appointments, and ensuring home care services are in place if ordered by your provider. Case managers coordinate services across the continuum of health care. They conduct care management by phone during business hours.

Prior Authorizations

We cover some services listed in the benefits chart only if your doctor or other provider gets approval from us in advance. Some of the covered services that need such approval include inpatient rehabilitation services, genetic molecular diagnosis test, spine surgery, bone growth stimulators and spinal cord stimulators. Other services that require prior authorization are marked with an ^ in the chart. For more information on services that require prior authorization by your provider, go to **ucare.org.**

The Benefits Chart section of the Evidence of Coverage includes this information for each of our plans. This information is also at **ucare.org.**

Understanding utilization management

Authorization and notification

One of the ways UCare makes sure you get excellent care is by partnering with your doctors to review certain types of services and procedures. We want you to get the care that is best for your needs.

This Summary of Benefits notes which types of care or services require notification or authorization. This list may change from time to time. Some examples include spine surgery and home health care.

Notification

Hospitals are required to notify UCare if you are admitted to a hospital, Long Term Care Facility, or Skilled Nursing Facility. UCare's clinical team will coordinate with your doctors to make sure you get the care you need. If needed, UCare may set up post-hospital care.

Authorization

Before some services will be covered, your provider must get approval from UCare. This is true whether the provider participates in a UCare network or is out-of-network.

To make a coverage decision, UCare's clinical team evaluates if the service is medically necessary, appropriate and effective for your need.

Prior authorization, or preservice review, means that before you get the service, your provider must provide information to UCare and request approval. If pre-approval is required for that service, it will only be covered if the approval was granted.

Urgent concurrent and concurrent review often occurs during a Long Term Care Facility, or Skilled Nursing Facility stay. UCare will review to see if your care might need to continue longer or if different care is needed.

Post-service review is needed if your doctor didn't request pre-service review. Your claim may have already been denied because authorization is required for coverage. After your doctor requests review, UCare will consider your situation and care plan to make sure you get the coverage you are entitled to as a UCare member.

If we deny a request made by you or your doctor, for medical services or pharmaceuticals, you or your doctor may appeal our decision. When you file an appeal, you or your Doctor may submit additional documentation that is relevant to your

appeal. Appeal requests are reviewed against current medical evidence and your benefit plan by physicians. If we deny your appeal, you will be given information on how to file a second level appeal.

Learn more
Go to ucare.org and click on "plan resources." UCare members can also look up services in their Evidence of Coverage and Annual Notice of Change documents. These documents note if notification and authorization is required. The Evidence of Coverage is provided to new members. Every renewal year, members receive an Annual Notice of Change that explains any changes to their plan benefits.

Consider Medicare coverage limits

The following items and services are not covered under Original Medicare or by our plan:

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Private room in a hospital, except when it is considered medically necessary or if it is the only option available
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television
- Full-time nursing care in your home
- Custodial care — care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation
- Fees charged for care by your immediate relatives or members of your household
- Cosmetic surgery or procedures, unless covered in case of an accidental injury or for improvement of the functioning of a malformed body part. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine chiropractic care, other than manual manipulation of the spine to correct a subluxation
- Home-delivered meals (except some coverage for members with congestive heart failure)
- Routine foot care, except for the limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Hearing aids (except for EssentiaCare Grand)
- Radial keratotomy, LASIK surgery, vision therapy and other low-vision aids. Eyewear except for one pair of eyeglasses (or contact lenses) after cataract surgery and non Medicare-covered eyewear up to the allowed amount.
- Reversal of sterilization procedures, and/or non prescription contraceptive supplies
- Acupuncture (except for chronic low back pain)
- Naturopath services (uses natural or alternative treatments)

Our plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

Dental coverage limitations

Frequency limits and waiting periods do not apply to plans with a yearly dental allowance. Otherwise these limitations apply to all plans.

- Endodontics: Limited to one (1) per tooth per lifetime.
- Periodontics (other than periodontal maintenance cleanings): Coverage is limited to one (1) non-surgical periodontal treatment and one (1) surgical periodontal treatment per quadrant every 36 months.
- Bone grafting: Coverage is limited to once per site (upper/lower ridge) in conjunction with building the bony ridge needed for successful placement of an implant or removable prosthetics (partial/full dentures).

- Major restorative services: Benefit for the replacement of a crown or an onlay will be provided only after a 60 month period, measured from the last date the covered dental service was performed.
- Prosthetics — removable and fixed: A prosthetic appliance (denture or bridge) for the purpose of replacing an existing appliance will be covered only after 60 months.
- Implant services: Replacing a single missing tooth. Coverage for implants is limited to once per tooth per lifetime (also see Exclusion #18).

Dental coverage exclusions

These exclusions are specific to dental coverage. Some of these exclusions may be covered under your medical benefit:

1. Dental services that are not necessary or specifically covered
2. Hospitalization or other facility charges
3. Prescription drugs
4. Any dental procedure performed solely as a cosmetic procedure
5. Charges for dental procedures completed prior to the member's effective date of coverage
6. Anesthesiologist services
7. Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles, except as provided under Oral Surgery in the Evidence of Coverage
9. Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions
10. Oral hygiene instruction and periodontal exam
11. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture
12. Any oral surgery that includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery in the Evidence of Coverage
13. Analgesia (nitrous oxide)
14. Removable unilateral dentures
15. Temporary procedures
16. Splinting
17. Consultations by the treating provider and office visits
18. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's effective date. Exception: This exclusion will not apply for any member who has been continuously covered under a UCare Medicare Plan for more than 24 months
19. Occlusal analysis, occlusal guards (night guards) and occlusal adjustments (limited and complete)
20. Veneers (bonding of coverings to the teeth)
21. Orthodontic treatment procedures
22. Corrections to congenital conditions, other than for congenital missing teeth
23. Athletic mouth guards
24. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment, except as noted in the Evidence of Coverage
25. Space maintainers

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.

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, or by calling our 24-hour Compliance Hotline at 612-676-6525. 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.

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

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 canceled 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 Services at the toll-free number listed on the back of your member card. This information is also available in other forms to people with disabilities. Please ask us for that information.

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 ကျိာ်ဖာယိ, နမၤနှ်ၤ ကျိာ်ဖာတၢ်မၤစၢၤလၢ 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 ភាសារ៉ខ្មែរ, រសរាជំនួយរ័ផ្តកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរ៉ីអ្នក។ 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).

Notes

Compare benefit highlights

For services at in-network providers

	Access	Secure	Grand
2022 monthly plan premium (you must continue to pay your Part B premium)	$0	$35	$109
Preventive care	$0 copay for many services	$0 copay for many services	$0 copay for many services
Doctor visits (no referrals needed)	Primary: $22 copay Specialist: $50 copay	Primary: $0 copay Specialist: $45 copay	Primary: $0 copay Specialist: $30 copay
Inpatient hospital care (per admission)	$300 copay per **day** (days 1–5); then 100% covered	$300 copay per **day** (days 1–5); then 100% covered	$250 copay per **stay** (not per day); then 100% covered
Diagnostic tests, x-rays	20% coinsurance	10% coinsurance up to a maximum of $150 per day	10% coinsurance up to a maximum of $50 per day
Lab services	$0 copay	$0 copay	$0 copay
Medicare Part D prescription drug coverage	Annual deductible: Tier 1 = $0 Tiers 2–5 = $480 Copays based on drug tiers, as low as $3	Annual deductible: Tiers 1 & 2 = $0 Tiers 3–5 = $400 Copays based on drug tiers, as low as $1	Annual deductible: Tiers 1 & 2 = $0 Tiers 3–5 = $250 Copays based on drug tiers, as low as $1
Hearing aids	Not covered	Not covered	$500 yearly hearing aid allowance
Dental coverage	$250 yearly allowance	Routine dental with optional coverage available	Routine dental with optional coverage available
Eyewear	$100 eyewear/ contacts allowance	$100 eyewear/ contacts allowance	$200 eyewear/ contacts allowance
Fitness program	Basic membership	Basic membership	Basic membership
Over-the-counter allowance	$50 twice a year	$50 twice a year	$50 twice a year
Maximum out-of-pocket	$6,500	$4,500	$3,500
Worldwide emergency care	$90 copay	$90 copay	$90 copay
Coverage when traveling	Out-of-network coverage	Out-of-network coverage	Out-of-network coverage

EssentiaCare

Essentia Health + UCare

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