2023 Summary of Benefits
EssentiaCare Comparison Guide
Medicare Advantage
your shopping checklist

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

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

care.org/medicare123 or call 1-877-671-1061
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.

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.

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

<table>
<thead>
<tr>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months before</td>
<td>3 months after</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 dental, prescription eyewear 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

prescription drug coverage
dental coverage
coverage when traveling
fitness options
over-the-counter benefit
prescription eyewear and hearing
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 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
Fitness options
Refer to the chart on page 22 for more information on these benefits.

One Pass fitness program
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 23,000 participating fitness locations nationwide, plus:

• More than 32,000 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
• More than 30,000 social activities, community classes, and events available for online or in-person participation
• Find participating locations near you at ucare.org/onepass or call 1-877-504-6830 (TTY 711), 8 am–9 pm, Monday–Friday

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/fitness.

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 2023 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 22,000 preferred and 42,000 standard pharmacies in our plan network.

Save more with preferred pharmacies
Participating pharmacies include:

• Essentia Health
• Coborn’s
• Costco
• Cub Foods
• Essentia Mail Order Pharmacy and Express Scripts Mail Order provide a 90-day supply for two copays
• CVS/Target
• Hy-Vee
• Sam’s Club/Walmart

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.

Low copays on select formulary insulins
You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on even if you haven’t paid your deductible.
Coverage when traveling

EssentiaCare plans travel with you whether you’re gone for a couple weeks or a few months.

As an EssentiaCare member, here’s how it works. In addition to the more than 2,100 Essentia Health providers and its partners, you have access to out-of-state providers with our expanded MultiPlan® national network. At these providers, your plan works the same as in-network — giving you the same great coverage.

EssentiaCare also provides flexibility to see providers out-of-network that accept Medicare, but you may pay more.

Always know that emergencies are covered while traveling in the U.S. and worldwide with a copay.

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.

Over-the-counter benefit

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) benefit through Healthy Savings®. You’ll receive an allowance to use twice a year. Dollars you don’t use will expire on June 30 and Dec. 31. You cannot redeem your allowance for cash. Eligible items include cough drops, first aid supplies, pain relief, sinus medications, toothpaste, and much more. 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
Dental, prescription eyewear and hearing services for EssentiaCare Secure and EssentiaCare Grand plans

Dental coverage

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

With EssentiaCare Secure and Grand plans, we include routine dental coverage and flexibility to purchase additional 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.”

Hearing services

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

Our plans include coverage for routine hearing tests and diagnostic hearing exams. Members of EssentiaCare Grand also receive a $500 annual allowance to use toward the purchase of hearing aids.

Prescription eyewear

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

EssentiaCare Secure and Grand plans offer a vision benefit with a dollar allowance for prescription glasses or contact lenses. These allowances range from $100 to $200, depending on the plan you choose.

Dental, prescription eyewear and hearing aids, for EssentiaCare Access plan

Flexible benefit allowance

With EssentiaCare Access, you have a flexible benefit allowance of $400 for eligible dental, hearing aids and prescription eyewear at any provider.

Flexible benefits allow you to choose the benefits you need most. Use your flexible benefit allowance on one or a combination of services.
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 an 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
ucare.org/medicare123
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by mail
fill out the enrollment form and mail in the postage-paid envelope

phone
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Plan benefit details

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### Preventive Care

#### Preventive Care continued

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu and pneumonia vaccines</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Mammogram screening, prostate cancer screening exam, bone mass measurement, diabetes screening, preventive colorectal cancer screening</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

#### Emergency / Urgent Care — network does not apply

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgently needed services</td>
<td>$45 copay</td>
<td>$45 copay</td>
</tr>
</tbody>
</table>

#### Diagnostic Tests, Radiation Therapy, X-rays and Lab Services

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic tests (e.g., MRI and CT scans), radiation therapy and X-rays</td>
<td>In-network $0 copay</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>Lab services (e.g., Protime INR, cholesterol)</td>
<td>In-network $0 copay</td>
<td>Out-of-network</td>
</tr>
</tbody>
</table>

#### Hearing Services

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic hearing exam</td>
<td>$50 copay</td>
<td>$45 copay</td>
</tr>
<tr>
<td>Routine hearing exam</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Annual allowance for hearing aids</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

#### Dental Coverage

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage includes</td>
<td>$400 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids and prescription eyewear</td>
<td>Routine dental with optional coverage available</td>
</tr>
</tbody>
</table>

#### Premium

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>+ $25 per month</td>
<td>+ $25 per month</td>
</tr>
</tbody>
</table>

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### Medical Coverage

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023 monthly plan premium (you must continue to pay your Medicare Part B premium)</td>
<td>$0</td>
<td>$33</td>
</tr>
<tr>
<td>Medical deductible</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Medicare Part D deductible</td>
<td>$35</td>
<td>$100</td>
</tr>
</tbody>
</table>
| Maximum out-of-pocket cost you will pay |Tier 1 = $0
Tiers 2–5 = $395
Tiers 1 & 2 = $0
Tiers 3–5 = $345
Tiers 1–5 = $0 |

#### Hospital Care

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital care (per admission) $300 copay per day (days 1–5), then 100% covered</td>
<td>$300 copay per day (days 1–5), then 100% covered</td>
<td>$250 copay per stay (not per day), then 100% covered</td>
</tr>
<tr>
<td>Outpatient hospital or procedure</td>
<td>$395 copay</td>
<td>$350 copay</td>
</tr>
<tr>
<td>Ambulatory surgery center</td>
<td>$395 copay</td>
<td>$350 copay</td>
</tr>
</tbody>
</table>

#### Doctor Visits — in person or telehealth for Medicare-approved services

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>In-network $10 copay</td>
<td>Out-of-network $50 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>In-network $50 copay</td>
<td>Out-of-network $80 copay</td>
</tr>
<tr>
<td>E-visits through Essentia MyChart</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

#### Preventive Care

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Welcome to Medicare” preventive visit (if in the first 12 months on Part B)</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Annual Wellness Exam (if you’ve had Part B for more than 12 months)</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

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.
## Dental Coverage continued

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$0</td>
<td>$75 per year</td>
</tr>
<tr>
<td><strong>Annual plan maximum</strong></td>
<td>$400</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Oral examinations</strong></td>
<td>$400 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids and prescription eyewear.</td>
<td>One per year* (two total with purchase of optional coverage)</td>
</tr>
<tr>
<td><strong>Routine cleanings</strong></td>
<td>One per year* (two total with purchase of optional coverage)</td>
<td>One per year* (two total with purchase of optional coverage)</td>
</tr>
<tr>
<td><strong>X-rays</strong></td>
<td>Annual bitewing* (full mouth every 5 years with purchase of optional coverage)</td>
<td>Annual bitewing* (full mouth every 5 years with purchase of optional coverage)</td>
</tr>
<tr>
<td><strong>Fluoride treatment</strong></td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td><strong>Periodontal maintenance cleanings</strong></td>
<td>One per year* (more with purchase of optional coverage)</td>
<td>One per year* (more with purchase of optional coverage)</td>
</tr>
<tr>
<td><strong>Basic restorative services (e.g., fillings, root canals, periodontal services)</strong></td>
<td>30% coinsurance with purchase of optional coverage</td>
<td>30% coinsurance with purchase of optional coverage</td>
</tr>
<tr>
<td><strong>Major restorative procedures (e.g., crowns, bridges, implants, dentures)</strong></td>
<td>60% coinsurance with purchase of optional coverage</td>
<td>60% coinsurance with purchase of optional coverage</td>
</tr>
</tbody>
</table>

## Vision Services

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic eye exam</strong></td>
<td>$35 copay</td>
<td>$45 copay</td>
</tr>
<tr>
<td><strong>Annual routine eye exam</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Prescription eyeglasses or contact lenses after cataract surgery</strong></td>
<td>20% coinsurance</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Annual allowance for prescription eyeglasses or contacts at your preferred eyewear retailer that accepts Mastercard</strong></td>
<td>$400 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids and prescription eyewear.</td>
<td>$100</td>
</tr>
</tbody>
</table>

*These services are included without purchase of optional coverage and no deductible applies. For dental limitations and exclusions, see pages 27–28.

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

## Mental Health Services

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient hospital stay (90-day limit per stay)</strong></td>
<td>$300 copay per day (days 1–5); then 100% covered</td>
<td>$300 copay per day (days 1–5); then 100% covered</td>
</tr>
<tr>
<td><strong>Outpatient mental health care</strong></td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
</tbody>
</table>

## Skilled Nursing Facility Care (or swing bed)*

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care in a skilled nursing facility with no prior 3-day hospital stay required</strong></td>
<td>$0 copay per day for days 1–20; $196 copay per day for days 21–100; per benefit period</td>
<td>$0 copay per day for days 1–20; $196 copay per day for days 21–100; per benefit period</td>
</tr>
</tbody>
</table>

## Other Services

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical therapy</strong></td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td><strong>Ambulance (within the U.S. and its territories)</strong></td>
<td>$350 copay</td>
<td>$375 copay</td>
</tr>
<tr>
<td><strong>Transportation (non-emergency)</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Medicare Part B Drugs</strong></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>Chiropractic services through ChiroCare network</strong></td>
<td>Manual manipulation of the spine to correct subluxation</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>Doctor visit copays apply (see page 18)</td>
<td>Doctor visit copays apply (see page 18)</td>
</tr>
<tr>
<td><strong>Podiatry services</strong></td>
<td>$50 copay</td>
<td>$45 copay</td>
</tr>
<tr>
<td><strong>Over-the-counter benefit through Healthy Savings</strong></td>
<td>$75 allowance twice a year</td>
<td>$75 allowance twice a year</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td><strong>Prosthetic devices (e.g., braces, colostomy bags and supplies)</strong></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

*Service requires prior authorization. Beginning April 1, 2023, certain drugs may have a lower coinsurance. Beginning July 1, 2023, you will not pay more than $35 for a one-month supply of Part B insulin and deductibles will not apply.
### Other Services continued

<table>
<thead>
<tr>
<th></th>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fitness options</strong></td>
<td>One Pass fitness</td>
<td>One Pass fitness</td>
<td>One Pass fitness</td>
</tr>
<tr>
<td></td>
<td>program or Health Club</td>
<td>program or Health Club</td>
<td>program or Health Club</td>
</tr>
<tr>
<td></td>
<td>Savings program</td>
<td>Savings program</td>
<td>Savings program</td>
</tr>
<tr>
<td><strong>Diabetic supplies</strong></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>• Continuous blood</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>glucose monitors</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>• Other glucose monitors</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>• Test strips, and lancets</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>• Inserts and shoes</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>(Insulin and syringes</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>covered under Medicare</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Part D)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

### Coverage When Traveling — EssentiaCare covers you in-network at Essentia Health providers, its partners and at out-of-state providers in the MultiPlan national network, plus more.

**Within the U.S. — care from any provider that accepts Medicare**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary out-of-network</td>
<td>$50 copay</td>
<td>$45 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Specialist out-of-network</td>
<td>$80 copay</td>
<td>$75 copay</td>
<td>$75 copay</td>
</tr>
<tr>
<td>Most other non-emergency services</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>received out-of-network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency care</td>
<td>$100 copay</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgently needed services</td>
<td>$45 copay</td>
<td>$45 copay</td>
<td>$45 copay</td>
</tr>
<tr>
<td>Ambulance (within the U.S. and its territories)</td>
<td>$350 copay</td>
<td>$375 copay</td>
<td>$300 copay</td>
</tr>
<tr>
<td>Includes air and/or ground</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Worldwide Emergency Care (outside the U.S. and its territories)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care including</td>
<td>$100 copay</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>post-stabilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground ambulance to the nearest</td>
<td>$100 copay</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>hospital for emergency care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail — 30-day supply</th>
<th>Retail — 30-day supply</th>
<th>Retail — 30-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preferred</td>
<td>Standard</td>
<td>Preferred</td>
</tr>
<tr>
<td><strong>Tier 1</strong></td>
<td>$3 copay</td>
<td>$12 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td></td>
<td>Select insulin</td>
<td>17% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preferred: $30 copay</td>
<td>Standard: $20 copay</td>
<td>Standard: $20 copay</td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
<td>30-day supply</td>
<td>30-day supply</td>
<td>30-day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred</td>
<td>Standard</td>
<td>Preferred</td>
</tr>
<tr>
<td></td>
<td>$10 copay</td>
<td>$20 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td>30-day supply</td>
<td>30-day supply</td>
<td>30-day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred</td>
<td>Standard</td>
<td>Preferred</td>
</tr>
<tr>
<td></td>
<td>$17 copay</td>
<td>$25 copay</td>
<td>$17 copay</td>
</tr>
<tr>
<td><strong>Tier 4</strong></td>
<td>30-day supply</td>
<td>30-day supply</td>
<td>30-day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred</td>
<td>Standard</td>
<td>Preferred</td>
</tr>
<tr>
<td></td>
<td>$50 coinsurance</td>
<td>Standard: $25 copay</td>
<td>Standard: $25 copay</td>
</tr>
<tr>
<td><strong>Tier 5</strong></td>
<td>30-day supply</td>
<td>30-day supply</td>
<td>30-day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred</td>
<td>Standard</td>
<td>Preferred</td>
</tr>
<tr>
<td></td>
<td>$25 coinsurance</td>
<td>Standard: $25 copay</td>
<td>Standard: $25 copay</td>
</tr>
</tbody>
</table>

**Initial Coverage Phase:** From $0 to $4,660 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: $0 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: $10 copay
    - Standard: $20 copay

### Tier 3
- Preferred brand drugs
  - Select insulin
    - Preferred: $30 copay
    - Standard: $35 copay
  - Retail — 30-day supply
    - Preferred: $47 copay
    - Standard: $47 copay
  - Retail — 30-day supply
    - Preferred: $47 copay
    - Standard: $47 copay

### Tier 4
- Non-preferred drugs
  - Retail — 30-day supply
    - Preferred: $25 copay
    - Standard: $25 copay
  - Retail — 30-day supply
    - Preferred: $27 copay
    - Standard: $27 copay
  - Retail — 30-day supply
    - Preferred: $33 copay
    - Standard: $33 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.
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 Case Management is a short-term (3–6 month) telephonic program for members challenged by multiple chronic health conditions. We offer care management to members with select diagnoses who transition to home from a hospital or skilled nursing facility. The Case Management team consists of registered nurses whose primary focus is on assisting our members with medical case management needs such as health decision support and disease specific education. The case management team also works with internal and external resources to provide the member with needed support and help with attaining best health outcomes. 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 covered services that need such approval include inpatient rehabilitation services, genetic molecular diagnosis tests, lumbar spine surgery, bariatric surgery, vein procedures, 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. In addition, 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. If 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 under 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 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 attendance 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 function 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 or 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 contraceptives
- 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 12 months.
- Bone grafting: Coverage is limited to once per side of the lower jaw and to one bone grafting procedure for the purpose of 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), replacement of teeth, periodontal splinting, and gnathologic recordings
   - 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
8. Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions
9. Oral hygiene instruction and periodontal exam
10. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture
11. Any oral surgery that includes surgical endodontics (apicectomy, retrograde filling) other than that listed under Oral Surgery in the Evidence of Coverage
12. Analgesia
13. Naturotherapy (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 an EssentiaCare Medicare Plan for more than 24 months
19. Occlusal analysis, occlusal guards (night guards) and occlusal adjustments (limited and complete)
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, Att: Privacy Officer, 1330 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 relates to your past, present, or future health or physical or mental condition and the provision of health care to you. 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, eligibility and enrollment 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 fraud, quality activities, health survey information,underwriting, actuarial studies, premium rating, legal and regulatory compliance, risk management, professional peer review, litigation, accreditation, fraudulent and abusive claims, 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 do 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 purposes with your authorization. We treat information about current 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 purposes. We may also 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 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 the authority to represent you.

We may ask you to make your request in writing. Information includes records we use to make decisions about payment, treatment, and health care operations. If we deny your request, we will tell you in writing our reason for the denial.

You have the right to ask us to correct or add missing information about you that we have about you at any time. You may request us to cancel information that is accurate but inappropriate, irrelevant, excessive, injected, used unlawfully, or obtained from an unauthorized source. If we cannot correct or add information, you have the right to have a statement of disagreement included with your information. You have the right to request us to destroy information including records we use to make decisions about payment, treatment, and health care operations. If we destroy your information, you still have the right to have a record of the information that is destroyed included in your health record.

You have the right to receive a listing of the times 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, and required to disclose as part of a health plan’s legal, administrative, or business operations; information that is shared as a result of an allowed use or disclosure; or information disclosed to you in connection with research, public health, public policy matters, or 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 fee; please call us at 1-877-671-1061 to get a price quote. If you have questions about this, please contact us at the address provided at the end of this Notice.

ucare.org/medicare123 or call 1-877-671-1061
Compare benefit highlights

For services at in-network providers

<table>
<thead>
<tr>
<th>Access</th>
<th>Secure</th>
<th>Grand</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023 monthly plan premium (you must continue to pay your Part B premium)</td>
<td>$0</td>
<td>$33</td>
</tr>
<tr>
<td>Preventive care</td>
<td>$0 copay for many services</td>
<td>$0 copay for many services</td>
</tr>
<tr>
<td>Doctor visits</td>
<td>Primary: $10 copay Specialist: $50 copay</td>
<td>Primary: $0 copay Specialist: $45 copay</td>
</tr>
<tr>
<td>Inpatient hospital care (per admission)</td>
<td>$300 copay per day (days 1–5); then 100% covered</td>
<td>$300 copay per day (days 1–5); then 100% covered</td>
</tr>
<tr>
<td>Diagnostic tests, X-rays</td>
<td>20% coinsurance</td>
<td>10% coinsurance up to a maximum of $150 per day</td>
</tr>
<tr>
<td>Lab services</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Medicare Part D prescription drug coverage</td>
<td>Annual deductible: Tier 1 = $0 Tiers 2–5 = $395 Copays based on drug tiers, as low as $3</td>
<td>Annual deductible: Tiers 1 &amp; 2 = $0 Tiers 3–5 = $345 Copays based on drug tiers, as low as $1</td>
</tr>
<tr>
<td>Dental coverage</td>
<td>$400 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids and prescription eyewear</td>
<td>Routine dental with optional coverage available</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Not covered</td>
<td>$500 yearly hearing aid allowance</td>
</tr>
<tr>
<td>Prescription eyewear</td>
<td>$100 prescription eyeglasses/contacts allowance</td>
<td>$200 prescription eyeglasses/contacts allowance</td>
</tr>
<tr>
<td>Fitness program</td>
<td>Basic membership</td>
<td>Basic membership</td>
</tr>
<tr>
<td>Over-the-counter benefit</td>
<td>$75 twice a year</td>
<td>$75 twice a year</td>
</tr>
<tr>
<td>Maximum out-of-pocket</td>
<td>$4,400</td>
<td>$4,500</td>
</tr>
<tr>
<td>Worldwide emergency care</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Coverage when traveling</td>
<td>Out-of-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
</tbody>
</table>