2018

Summary of Benefits

UCare for Seniors Essentials Rx (HMO-POS)
UCare for Seniors Value (HMO-POS)
UCare for Seniors Value Plus (HMO-POS)
UCare for Seniors Classic (HMO-POS)

Y0120_2459_081817_3 CMS Accepted (08222017)

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 **612-676-6500 (voice)** or toll free at **1-866-457-7144 (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 **612-676-6500** or toll free at **1-866-457-7144 (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 **612-676-6500** or toll free at **1-866-457-7144 (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: Complaints, Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-052
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 612-676-6500/1-866-457-7144 (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 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-6500/1-866-457-7144 (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 612-676-6500/1-866-457-7144 (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 612-676-6500/1-866-457-7144（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-6500/1-866-457-7144 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-6500/1-866-457-7144 (**መስማት ለተሳናቸው**: 612-676-6810/1-800-688-2534).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ်၊ ကျိာ်အတၢ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ខ្មរ, រសវាជំនួយរ័ផ្តកភាសា ដោយមិនគិតឈួល គឺអាច មានសំរាប់បំររីអ្នក។ ចូរ ទូរស័ព្ទ 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 612-676-6500/1-866-457-7144 (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 612-676-6500/1-866-457-7144 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-6500/1-866-457-7144 (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 612-676-6500/1-866-457-7144 (TTY: 612-676-6810/1-800-688-2534).

Summary of Benefits
January 1, 2018 – December 31, 2018

UCare for Seniors Value, *UCare for Seniors* Value Plus, *UCare for Seniors* Essentials Rx and *UCare for Seniors* Classic

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. 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. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as *UCare for Seniors* Value, *UCare for Seniors* Value Plus, *UCare for Seniors* Essentials Rx or *UCare for Seniors* Classic).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what *UCare for Seniors* Value, *UCare for Seniors* Value Plus, *UCare for Seniors* Essentials Rx and *UCare for Seniors* Classic.

- If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **Medicare & You** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About *UCare for Seniors* Value, *UCare for Seniors* Value Plus, *UCare for Seniors* Essentials Rx and *UCare for Seniors* Classic.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Additional Benefits
- Optional Benefits (when available, you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us locally at **612-676-3600** (TTY/TDD **612-676-6810**), or toll free at **1-877-523-1515** (TTY/TDD **1-800-688-2534**).

UCare for Seniors is an HMO-POS plan with a Medicare contract. Enrollment in *UCare for Seniors* depends on contract renewal.

Things to Know About *UCare for Seniors* Value, *UCare for Seniors* Value Plus, *UCare for Seniors* Essentials Rx and *UCare for Seniors* Classic

Hours of Operation	You can call us 24 hours a day, 7 days a week.
Phone Numbers	If you are a member of this plan, call locally **612-676-3600** (TTY/TDD **612-676-6810**), or toll free at **1-877-523-1515** (TTY/TDD **1-800-688-2534**). If you are not a member of this plan, call locally **612-676-3500** (TTY/TDD **612-676-6810**), or toll free at **1-877-523-1518** (TTY/TDD **1-800-688-2534**).
Website	**ucare.org**

Who can join?

To join *UCare for Seniors* Value you must have both Medicare Part A and Medicare Part B, and live in our service area.

Our service area includes the entire state of Minnesota.

To join *UCare for Seniors* Essentials Rx you must have both Medicare Part A and Medicare Part B, and live in our service area.

Our service area includes the following counties in Minnesota: Aitkin, Becker, Beltrami, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Douglas, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Red Lake, Roseau, St. Louis, Todd, Wadena, Wilkin.

To join *UCare for Seniors* Value Plus and *UCare for Seniors* Classic, you must have both Medicare Part A and Medicare Part B, and live in our service area.

Our service area includes the following counties in Minnesota: Aitkin, Becker, Carlton, Cass, Clay, Cook, Crow Wing, Hubbard, Kanabec, Lake, Morrison, Pine, St. Louis.

Which doctors, hospitals, and pharmacies can I use?

UCare for Seniors Value has a network of doctors, hospitals, and other providers. For some services you can use providers that are not in our network.

UCare for Seniors Value Plus, *UCare for Seniors* Essentials Rx and *UCare for Seniors* Classic have a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Note: *UCare for Seniors* Value does **NOT** cover Medicare Part D prescription drugs.

- You can see our plan's provider and pharmacy directory at our website, **ucare.org**.
- Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers — and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more* than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

UCare for Seniors Value covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

UCare for Seniors Value Plus, *UCare for Seniors* Essentials Rx and *UCare for Seniors* Classic cover Part D drugs. In addition, these plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **ucare.org**.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs under *UCare for Seniors* Value Plus, *UCare for Seniors* Essentials Rx and *UCare for Seniors* Classic?

UCare for Seniors Value Plus, *UCare for Seniors* Essentials Rx, and *UCare for Seniors* Classic group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap and Catastrophic Coverage.

Summary of Benefits
January 1, 2018 – December 31, 2018

For contract H2459 - plans 023-002, 001, 022-002, 021-002

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE	
Your monthly premium	$66 per month. In addition, you must continue to pay your Medicare Part B premium.	$39 per month. In addition, you must continue to pay your Medicare Part B premium.	
Your deductible	$300 per year for Part D prescription drugs.	This plan does not have a deductible, as Part D prescription drugs are not covered.	
Your maximum out-of-pocket costs for medical and hospital care	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. • $10,000 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. • $10,000 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.	

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	$150 per month. In addition, you must continue to pay your Medicare Part B premium.	$196 per month. In addition, you must continue to pay your Medicare Part B premium.
	$250 per year for Part D prescription drugs, excluding Tier 1.	$200 per year for Part D prescription drugs, excluding Tier 1.
	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. • $10,000 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. • $10,000 for services you receive from out-of-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Covered Medical and Hospital Benefits

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Some of the covered benefits listed are covered only if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered benefits that need approval in advance are marked by an asterisk(*).		
Inpatient Hospital Care **Includes inpatient acute, inpatient rehabilitation*, long-term care hospitals* and other types of inpatient hospital services.**	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: - $300 copay per day for days 1 through 5. - Thereafter, you pay a $0 copay for additional Medicare-covered days. • Out-of-network: - 20% of the cost per stay. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: - $400 copay per stay. • Out-of-network: - 20% of the cost per stay. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Outpatient Hospital Coverage	• In-network: – $300 copay for each Medicare-covered surgery or procedure at an outpatient department of a hospital or ambulatory surgical center. – 10% coinsurance for all other Medicare-covered services provided in an outpatient department of a hospital or ambulatory surgical center, not to exceed a daily maximum of $75. • Out-of-network: – 20% coinsurance for each Medicare-covered surgery, procedure, and other services provided in an outpatient department of a hospital or ambulatory surgical center.	• In-network: – $250 copay for each Medicare-covered surgery or procedure at an outpatient department of a hospital or ambulatory surgical center. – 10% coinsurance for all other Medicare-covered services provided in an outpatient department of a hospital or ambulatory surgical center, not to exceed a daily maximum of $50. • Out-of-network: – 20% coinsurance for each Medicare-covered surgery, procedure, and other services provided in an outpatient department of a hospital or ambulatory surgical center.

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: - $400 copay per stay. • Out-of-network: - 20% of the cost per stay. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: - $250 copay per stay. • Out-of-network: - 20% of the cost per stay. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.
	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
	• In-network: – $250 copay for each Medicare-covered surgery or procedure at an outpatient department of a hospital or ambulatory surgical center. – 10% coinsurance for all other Medicare-covered services provided in an outpatient department of a hospital or ambulatory surgical center, not to exceed a daily maximum of $50. • Out-of-network: – 20% coinsurance for each Medicare-covered surgery, procedure, and other services provided in an outpatient department of a hospital or ambulatory surgucal center.	• In-network: – $150 copay for each Medicare-covered surgery or procedure at an outpatient department of a hospital or ambulatory surgical center. – $0 copayment for all other Medicare-covered services provided in an outpatient department of a hospital or ambulatory surgical center. • Out-of-network: – 20% coinsurance for each Medicare-covered surgery, procedure, and other services provided in an outpatient department of a hospital or ambulatory surgical center.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Doctor's Office Visits	Primary care physician visit: • In-network: $20 copay. • Out-of-network: 20% of the cost. Specialist visit: • In-network: $45 copay. • Out-of-network: 20% of the cost.	Primary care physician visit: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Specialist visit: • In-network: $35 copay. • Out-of-network: 20% of the cost.
Preventive Care	• In-network: You pay nothing. • Out-of-network: You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening. • Alcohol misuse counseling. • Bone mass measurement. • Breast cancer screening (mammogram). • Cardiovascular disease (behavioral therapy). • Cardiovascular screenings. • Cervical and vaginal cancer screening. • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy). • Depression screening. • Diabetes screenings. • HIV screening. • Medical nutrition therapy services. • Obesity screening and counseling. • Prostate cancer screenings (PSA). • Sexually transmitted infections screening and counseling.	• In-network: You pay nothing. • Out-of-network: You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening. • Alcohol misuse counseling. • Bone mass measurement. • Breast cancer screening (mammogram). • Cardiovascular disease (behavioral therapy). • Cardiovascular screenings. • Cervical and vaginal cancer screening. • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy). • Depression screening. • Diabetes screenings. • HIV screening. • Medical nutrition therapy services. • Obesity screening and counseling. • Prostate cancer screenings (PSA). • Sexually transmitted infections screening and counseling.

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	Primary care physician visit: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Specialist visit: • In-network: $35 copay. • Out-of-network: 20% of the cost.	Primary care physician visit: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Specialist visit: • In-network: $20 copay. • Out-of-network: 20% of the cost.
	• In-network: You pay nothing. • Out-of-network: You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening. • Alcohol misuse counseling. • Bone mass measurement. • Breast cancer screening (mammogram). • Cardiovascular disease (behavioral therapy). • Cardiovascular screenings. • Cervical and vaginal cancer screening. • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy). • Depression screening. • Diabetes screenings. • HIV screening. • Medical nutrition therapy services. • Obesity screening and counseling. • Prostate cancer screenings (PSA). • Sexually transmitted infections screening and counseling.	• In-network: You pay nothing. • Out-of-network: You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening. • Alcohol misuse counseling. • Bone mass measurement. • Breast cancer screening (mammogram). • Cardiovascular disease (behavioral therapy). • Cardiovascular screenings. • Cervical and vaginal cancer screening. • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy). • Depression screening. • Diabetes screenings. • HIV screening. • Medical nutrition therapy services. • Obesity screening and counseling. • Prostate cancer screenings (PSA). • Sexually transmitted infections screening and counseling.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE	
	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease). • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots. • "Welcome to Medicare" preventive visit (one-time). • Yearly "Wellness" visit. Any additional preventive services approved by Medicare during the contract year will be covered.	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease). • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots. • "Welcome to Medicare" preventive visit (one-time). • Yearly "Wellness" visit. Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency Care	$100 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$100 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	
Urgently Needed Services	$50 copay.	$50 copay.	

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease). • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots. • "Welcome to Medicare" preventive visit (one-time). • Yearly "Wellness" visit. Any additional preventive services approved by Medicare during the contract year will be covered.	• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease). • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots. • "Welcome to Medicare" preventive visit (one-time). • Yearly "Wellness" visit. Any additional preventive services approved by Medicare during the contract year will be covered.
	$100 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$100 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
	$50 copay.	$50 copay.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Diagnostic Tests, Lab and Radiology Services, and X-rays ***(Costs for these services may be different if received in an outpatient surgery setting.)***	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 10% of the cost, with a daily maximum of $75. • Out-of-network: 20% of the cost. Diagnostic tests and procedures: • In-network: 10% of the cost, with a daily maximum of $75. • Out-of-network: 20% of the cost. Lab services: • In-network: You pay nothing. • Out-of-network: You pay nothing. Outpatient X-rays: • In-network: 10% of the cost, with a daily maximum of $75. • Out-of-network: 20% of the cost. Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 10% of the cost, with a daily maximum of $75. • Out-of-network: 20% of the cost.	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost. Diagnostic tests and procedures: • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost. Lab services: • In-network: You pay nothing. • Out-of-network: You pay nothing. Outpatient X-rays: • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost. Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost.
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $45 copay. • Out-of-network: 20% of the cost. Routine hearing exam: • In-network: $0 copay. You are covered for up to 1 every year. • Out-of-network: Not covered. You are responsible for 100% of the cost.	Exam to diagnose and treat hearing and balance issues: • In-network: $35 copay. • Out-of-network: 20% of the cost. Routine hearing exam: • In-network: $0 copay. You are covered for up to 1 every year. • Out-of-network: Not covered. You are responsible for 100% of the cost.

	UCare for Seniors VALUE PLUS	UCare for Seniors CLASSIC
	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost. Diagnostic tests and procedures: • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost. Lab services: • In-network: You pay nothing. • Out-of-network: You pay nothing. Outpatient X-rays: • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost. Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 10% of the cost, with a daily maximum of $50. • Out-of-network: 20% of the cost.	Diagnostic radiology services (such as MRIs, CT scans): • In-network: You pay nothing. • Out-of-network: 20% of the cost. Diagnostic tests and procedures: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Lab services: • In-network: You pay nothing. • Out-of-network: You pay nothing. Outpatient X-rays: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing. • Out-of-network: 20% of the cost.
	Exam to diagnose and treat hearing and balance issues: • In-network: $35 copay. • Out-of-network: 20% of the cost. Routine hearing exam: • In-network: $0 copay. You are covered for up to 1 every year. • Out-of-network: Not covered. You are responsible for 100% of the cost.	Exam to diagnose and treat hearing and balance issues: • In-network: $20 copay. • Out-of-network: 20% of the cost. Routine hearing exam: • In-network: $0 copay. You are covered for up to 1 every year. • Out-of-network: Not covered. You are responsible for 100% of the cost.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): Preventive dental services: • Cleaning: - In-network: $0 copay. You are covered for up to 1 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Oral exam: - In-network: $0 copay. You are covered for up to 1 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Dental X-ray(s): - In-network: $0 copay. You are covered for up to 1 bite-wing X-ray every 12 months (one set - up to four films). - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Fluoride treatment: - In-network: $0 copay. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): Preventive dental services: • Cleaning: - In-network: $0 copay. You are covered for up to 1 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Oral exam: - In-network: $0 copay. You are covered for up to 1 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Dental X-ray(s): - In-network: $0 copay. You are covered for up to 1 bite-wing X-ray every 12 months (one set - up to four films). - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Fluoride treatment: - In-network: $0 copay. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule.

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): Preventive dental services: • Cleaning: - In-network: $0 copay. You are covered for up to 1 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Oral exam: - In-network: $0 copay. You are covered for up to 1 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Dental X-ray(s): - In-network: $0 copay. You are covered for up to 1 bite-wing X-ray every 12 months (one set - up to four films). - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Fluoride treatment: - In-network: $0 copay. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): Preventive dental services: • Cleaning: - In-network: $0 copay. You are covered for up to 3 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Oral exam: - In-network: $0 copay. You are covered for up to 2 every year. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Dental X-ray(s): - In-network: $0 copay. You are covered for up to 1 bite-wing X-ray every 12 months (one set – up to four films), 1 full mouth X-ray every 5 years and up to 4 periapical X-rays in a 12-month period. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule. • Fluoride treatment: - In-network: $0 copay. - Out-of-network: You must pay the difference between the dentist's fees and the UCare dental fee schedule.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-45 copay, depending on the service. • Out-of-network: 20% of the cost. Routine eye exam: • In-network: $0 copay. You are covered for up to 1 routine eye exam and up to two refractions every year. • Out-of-network: Not covered. You are responsible for 100% of the cost. Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay. • Out-of-network: 20% of the cost.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-35 copay, depending on the service. • Out-of-network: 20% of the cost. Routine eye exam: • In-network: $0 copay. You are covered for up to 1 routine eye exam and up to two refractions every year. • Out-of-network: Not covered. You are responsible for 100% of the cost. Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay. • Out-of-network: 20% of the cost.

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-35 copay, depending on the service. • Out-of-network: 20% of the cost. Routine eye exam: • In-network: $0 copay. You are covered for up to 1 routine eye exam and up to two refractions every year. • Out-of-network: Not covered. You are responsible for 100% of the cost. Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay. • Out-of-network: 20% of the cost.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-20 copay, depending on the service. • Out-of-network: 20% of the cost. Routine eye exam: • In-network: $0 copay. You are covered for up to 1 routine eye exam and up to two refractions every year. • Out-of-network: Not covered. You are responsible for 100% of the cost. Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay. • Out-of-network: 20% of the cost. Our plan pays up to $150 every year for prescription contact lenses, eyeglass lenses and eyeglass frames. The $150 is a combined maximum for both in-network and out-of-network providers.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Mental Health Care	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. • In-network: - $300 copay per day for days 1 through 5. - You pay nothing per day for days 6 through 90. • Out-of-network: - 20% of the cost per stay. Outpatient group therapy visit: • In-network: $40 copay. • Out-of-network: 20% of the cost. Outpatient individual therapy visit: • In-network: $40 copay. • Out-of-network: 20% of the cost. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. • In-network: - $400 copay per stay. • Out-of-network: - 20% of the cost per stay. Outpatient group therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. Outpatient individual therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. • In-network: - $400 copay per stay. • Out-of-network: - 20% of the cost per stay. Outpatient group therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. Outpatient individual therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. • In-network: - $250 copay per stay. • Out-of-network: - 20% of the cost per stay. Outpatient group therapy visit: • In-network: $20 copay. • Out-of-network: 20% of the cost. Outpatient individual therapy visit: • In-network: $20 copay. • Out-of-network: 20% of the cost. For inpatient hospital care, the benefit period begins with each admission and ends with discharge.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Skilled Nursing Facility (SNF)*	Our plan covers up to 100 days in a SNF. • In-network: - $0 copay per day for days 1 through 20; $150 copay per day for days 21 through 100 for each benefit period. • Out-of-network: - 20% of the cost per stay. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF) and ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row.	Our plan covers up to 100 days in a SNF. • In-network: - $0 copay per day for days 1 through 20; $125 copay per day for days 21 through 100 for each benefit period. • Out-of-network: - 20% of the cost per stay. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF) and ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row.
Outpatient Rehabilitation*	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day, for up to 36 sessions up to 36 weeks): • In-network: $45 copay. • Out-of-network: 20% of the cost. Occupational therapy visit: • In-network: $40 copay. • Out-of-network: 20% of the cost. Physical therapy and speech and language therapy visit: • In-network: $40 copay. • Out-of-network: 20% of the cost.	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day, for up to 36 sessions up to 36 weeks): • In-network: $35 copay. • Out-of-network: 20% of the cost. Occupational therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. Physical therapy and speech and language therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost.
Ambulance	• In-network: $200 copay. • Out-of-network: $200 copay.	• In-network: $100 copay. • Out-of-network: $100 copay.
Transportation	Not covered.	Not covered.

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	Our plan covers up to 100 days in a SNF. • In-network: - $0 copay per day for days 1 through 20; $125 copay per day for days 21 through 100 for each benefit period. • Out-of-network: - 20% of the cost per stay. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF) and ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row.	Our plan covers up to 100 days in a SNF. • In-network: - $0 copay per day for days 1 through 20; $100 copay per day for days 21 through 100 for each benefit period. • Out-of-network: - 20% of the cost per stay. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF) and ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row.
	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day, for up to 36 sessions up to 36 weeks): • In-network: $35 copay. • Out-of-network: 20% of the cost. Occupational therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. Physical therapy and speech and language therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost.	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day, for up to 36 sessions up to 36 weeks): • In-network: $20 copay. • Out-of-network: 20% of the cost. Occupational therapy visit: • In-network: $20 copay. • Out-of-network: 20% of the cost. Physical therapy and speech and language therapy visit: • In-network: $20 copay. • Out-of-network: 20% of the cost.
	• In-network: $100 copay. • Out-of-network: $100 copay.	• In-network: $100 copay. • Out-of-network: $100 copay.
	Not covered.	Not covered.

<table>
<tr><th></th><th>UCare for Seniors
ESSENTIALS Rx</th><th>UCare for Seniors
VALUE</th></tr>
<tr><td colspan="3">Prescription Drug Benefits</td></tr>
<tr><td>How much do I pay?</td><td>For Part B drugs such as chemotherapy drugs:
In-network: 20% of the cost.
Out-of-network: 20% of the cost.
Some Medicare Part B drugs may require prior authorization.</td><td>For Part B drugs such as chemotherapy drugs:
In-network: 20% of the cost.
Out-of-network: 20% of the cost.
Some Medicare Part B drugs may require prior authorization.
This plan does not cover Part D prescription drugs.</td></tr>
<tr><td>Initial Coverage</td><td>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.
You may get your drugs at network retail pharmacies and mail-order pharmacies.</td><td></td></tr>
<tr><td></td><td>Standard Retail Cost-Sharing<table><tr><th>Drug Tier</th><th>One-month supply</th><th>Three-month supply</th></tr><tr><td>Tier 1
Preferred
Generic Drugs</td><td>$7 copay</td><td>$21 copay</td></tr><tr><td>Tier 2
Generic Drugs</td><td>$15 copay</td><td>$45 copay</td></tr><tr><td>Tier 3
Preferred
Brand Drugs</td><td>$45 copay</td><td>$135 copay</td></tr><tr><td>Tier 4
Non-Preferred
Drugs</td><td>$100 copay</td><td>$300 copay</td></tr><tr><td>Tier 5
Specialty Drugs</td><td>27% of the cost</td><td>27% of the cost</td></tr></table></td><td></td></tr>
</table>

	UCare for Seniors VALUE PLUS			UCare for Seniors CLASSIC		
	For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Some Medicare Part B drugs may require prior authorization.			For Part B drugs such as chemotherapy drugs: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Some Medicare Part B drugs may require prior authorization.		
	After you pay your yearly deductible (for tiers 2-5), you pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.			After you pay your yearly deductible (for tiers 2-5), you pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail-order pharmacies.		
	Standard Retail Cost-Sharing			**Standard Retail Cost-Sharing**		
	Drug Tier	**One-month supply**	**Three-month supply**	**Drug Tier**	**One-month supply**	**Three-month supply**
	Tier 1 Preferred Generic Drugs	$6 copay	$18 copay	Tier 1 Preferred Generic Drugs	$5 copay	$15 copay
	Tier 2 Generic Drugs	$12 copay	$36 copay	Tier 2 Generic Drugs	$12 copay	$36 copay
	Tier 3 Preferred Brand Drugs	$40 copay	$120 copay	Tier 3 Preferred Brand Drugs	$40 copay	$120 copay
	Tier 4 Non-Preferred Drugs	$100 copay	$300 copay	Tier 4 Non-Preferred Drugs	$100 copay	$300 copay
	Tier 5 Specialty Drugs	28% of the cost	28% of the cost	Tier 5 Specialty Drugs	29% of the cost	29% of the cost

<table>
<tr><th></th><th>UCare for Seniors
ESSENTIALS Rx</th><th>UCare for Seniors
VALUE</th><th></th></tr>
<tr><td></td><td colspan="2">Standard Mail-Order Cost-Sharing
<table><tr><th>Drug Tier</th><th>Three-month supply</th></tr><tr><td>Tier 1
Preferred
Generic Drugs</td><td>$14 copay</td></tr><tr><td>Tier 2
Generic Drugs</td><td>$30 copay</td></tr><tr><td>Tier 3
Preferred
Brand Drugs</td><td>$90 copay</td></tr><tr><td>Tier 4
Non-Preferred
Drugs</td><td>$200 copay</td></tr><tr><td>Tier 5
Specialty Drugs</td><td>27% of the cost</td></tr></table></td><td></td><td></td></tr>
<tr><td></td><td colspan="2">If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy's status is preferred or non-preferred, or whether the prescription is a short-term (30-day supply) or long-term (90-day supply).</td><td></td><td></td></tr>
</table>

	UCare for Seniors VALUE PLUS		*UCare for Seniors* CLASSIC	
	Standard Mail-Order Cost-Sharing		**Standard Mail-Order Cost-Sharing**	
	Drug Tier	**Three-month supply**	**Drug Tier**	**Three-month supply**
	Tier 1 Preferred Generic Drugs	$12 copay	Tier 1 Preferred Generic Drugs	$10 copay
	Tier 2 Generic Drugs	$24 copay	Tier 2 Generic Drugs	$24 copay
	Tier 3 Preferred Brand Drugs	$80 copay	Tier 3 Preferred Brand Drugs	$80 copay
	Tier 4 Non-Preferred Drugs	$200 copay	Tier 4 Non-Preferred Drugs	$200 copay
	Tier 5 Specialty Drugs	28% of the cost	Tier 5 Specialty Drugs	29% of the cost
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug. Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy's status is preferred or non-preferred, or whether the prescription is a short-term (30-day supply) or long-term (90-day supply).		If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug. Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy's status is preferred or non-preferred, or whether the prescription is a short-term (30-day supply) or long-term (90-day supply).	

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE	
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand-name drugs (plus a portion of the dispensing fee) and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.		

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand-name drugs (plus a portion of the dispensing fee) and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan's cost for covered brand-name drugs (plus a portion of the dispensing fee) and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.
		Standard Retail Cost-Sharing

Drug Tier	**One-month supply**	**Three-month supply**
Tier 1 Preferred Generic Drugs	$5 copay	$15 copay
Tier 2 Generic Drugs	$12 copay	$36 copay

Standard Mail-Order Cost-Sharing

Drug Tier	**Three-month Supply**
Tier 1 Preferred Generic Drugs	$10 copay
Tier 2 Generic Drugs	$24 copay

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copayment for all other drugs.	
Additional Benefits		
Acupuncture	Not covered.	Not covered.
Chiropractic Care*	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay. • Out-of-network: Not covered. You are responsible for 100% of the cost.	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: You pay nothing. • Out-of-network: Not covered. You are responsible for 100% of the cost.
Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Diabetes self-management training: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Therapeutic shoes or inserts: • In-network: 20% of the cost. • Out-of-network: 20% of the cost.	Medicare-covered continuous glucose monitor and supplies: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Other Medicare-covered diabetes monitoring supplies: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Diabetes self-management training: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Therapeutic shoes or inserts: • In-network: You pay nothing. • Out-of-network: 20% of the cost.

	UCare for Seniors VALUE PLUS	UCare for Seniors CLASSIC
	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail-order) reach $5,000, you pay the greater of: • 5% of the cost, or • $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copayment for all other drugs.
	Not covered.	Not covered.
	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: You pay nothing. • Out-of-network: Not covered. You are responsible for 100% of the cost.	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: You pay nothing. • Out-of-network: Not covered. You are responsible for 100% of the cost.
	Medicare-covered continuous glucose monitor and supplies: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Other Medicare-covered diabetes monitoring supplies: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Diabetes self-management training: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Therapeutic shoes or inserts: • In-network: You pay nothing. • Out-of-network: 20% of the cost.	Medicare-covered continuous glucose monitor and supplies: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Other Medicare-covered diabetes monitoring supplies: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Diabetes self-management training: • In-network: You pay nothing. • Out-of-network: 20% of the cost. Therapeutic shoes or inserts: • In-network: You pay nothing. • Out-of-network: 20% of the cost.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE	
Durable Medical Equipment* (Wheelchairs, oxygen, etc.)	• In-network: 20% of the cost. • Out-of-network: 100% of the cost.	• In-network: 20% of the cost. • Out-of-network: 100% of the cost.	
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $45 copay. • Out-of-network: 20% of the cost.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $35 copay. • Out-of-network: 20% of the cost.	
Home Health Care*	• In-network: You pay nothing. • Out-of-network: 20% of the cost.	• In-network: You pay nothing. • Out-of-network: 20% of the cost.	
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	
Outpatient Substance Abuse*	Group therapy visit: • In-network: $40 copay. • Out-of-network: 20% of the cost. Individual therapy visit: • In-network: $40 copay. • Out-of-network: 20% of the cost.	Group therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. Individual therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost.	
Over-the-Counter Items	Not covered.	Not covered.	
Prosthetic Devices ***(braces, artificial limbs, etc.)***	Prosthetic devices: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Related medical supplies: • In-network: 20% of the cost. • Out-of-network: 20% of the cost.	Prosthetic devices: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Related medical supplies: • In-network: 20% of the cost. • Out-of-network: 20% of the cost.	

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	• In-network: 20% of the cost. • Out-of-network: 100% of the cost.	• In-network: 20% of the cost. • Out-of-network: 100% of the cost.
	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $35 copay. • Out-of-network: 20% of the cost.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $20 copay. • Out-of-network: 20% of the cost.
	• In-network: You pay nothing. • Out-of-network: 20% of the cost.	• In-network: You pay nothing. • Out-of-network: 20% of the cost.
	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
	Group therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost. Individual therapy visit: • In-network: $35 copay. • Out-of-network: 20% of the cost.	Group therapy visit: • In-network: $20 copay. • Out-of-network: 20% of the cost. Individual therapy visit: • In-network: $20 copay. • Out-of-network: 20% of the cost.
	Not covered.	Not covered.
	Prosthetic devices: • In-network: 20% of the cost. • Out-of-network: 20% of the cost. Related medical supplies: • In-network: 20% of the cost. • Out-of-network: 20% of the cost.	Prosthetic devices: • In-network: 10% of the cost. • Out-of-network: 20% of the cost. Related medical supplies: • In-network: 10% of the cost. • Out-of-network: 20% of the cost.

	UCare for Seniors ESSENTIALS Rx	*UCare for Seniors* VALUE
Renal Dialysis	• In-network: You pay nothing. • Out-of-network: You pay nothing.	• In-network: You pay nothing. • Out-of-network: You pay nothing.
Wellness programs	You may choose one of the two fitness options: • The SilverSneakers® fitness program includes free basic membership at participating locations and at-home fitness kits. For more information and healthy lifestyle tips, visit SilverSneakers.com. • UCare's Health Club Savings program offers up to $20 reimbursement of your membership fees for health clubs not in the SilverSneakers network.	You may choose one of the two fitness options: • The SilverSneakers® fitness program includes free basic membership at participating locations and at-home fitness kits. For more information and healthy lifestyle tips, visit SilverSneakers.com. • UCare's Health Club Savings program offers up to $20 reimbursement of your membership fees for health clubs not in the SilverSneakers network.
Optional Benefits *(you must pay an extra premium each month for these benefits)*		
Package 1: Optional Supplemental Dental	Benefits include: • Optional Supplemental Dental	Benefits include: • Optional Supplemental Dental
How much is the monthly premium?	Additional $20 per month. You must keep paying your Medicare Part B premium and your $66 monthly plan premium.	Additional $20 per month. You must keep paying your Medicare Part B premium and your $39 monthly plan premium.
How much is the deductible?	$75 per year.	$75 per year.
Is there a limit on how much the plan will pay?	This plan pays up to $1,000 every year, and has additional coverage limits for certain benefits.	This plan pays up to $1,000 every year, and has additional coverage limits for certain benefits.

	UCare for Seniors VALUE PLUS	*UCare for Seniors* CLASSIC
	• In-network: You pay nothing. • Out-of-network: You pay nothing.	• In-network: You pay nothing. • Out-of-network: You pay nothing.
	You may choose one of the two fitness options: • The SilverSneakers® fitness program includes free basic membership at participating locations and at-home fitness kits. For more information and healthy lifestyle tips, visit SilverSneakers.com. • UCare's Health Club Savings program offers up to $20 reimbursement of your membership fees for health clubs not in the SilverSneakers network.	You may choose one of the two fitness options: • The SilverSneakers® fitness program includes free basic membership at participating locations and at-home fitness kits. For more information and healthy lifestyle tips, visit SilverSneakers.com. • UCare's Health Club Savings program offers up to $20 reimbursement of your membership fees for health clubs not in the SilverSneakers network.
	Benefits include: • Optional Supplemental Dental	Benefits include: • Optional Supplemental Dental
	Additional $20 per month. You must keep paying your Medicare Part B premium and your $150 monthly plan premium.	Additional $21 per month. You must keep paying your Medicare Part B premium and your $196 monthly plan premium.
	$75 per year.	$50 per year.
	This plan pays up to $1,000 every year, and has additional coverage limits for certain benefits.	This plan pays up to $1,200 every year, and has additional coverage limits for certain benefits.

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