Individual and Family 2018
UCare Choices
Member Contract

UCare Choices Silver

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Important Contact Information

Customer Services
1-877-903-0070

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

Hours of operation: 8 a.m. to 6 p.m. Monday-Friday
Customer Services offers free language interpreter services for non-English speakers.

Mailing Address
UCare
P.O. Box 52
Minneapolis, MN 55440-0052

Street Address
500 Stinson Boulevard NE
Minneapolis, MN 55413-2615

Website
ucare.org

UCare 24/7 Nurse Line – 24 hours a day, seven days a week
When you or your child gets sick in the middle of the night or on the weekend, where can you turn for help? For reliable health information 24 hours a day, seven days a week, call the UCare 24/7 nurse line. The nurses will offer health advice when you're not feeling well or answer your health questions. They can also give you advice about whether you need to go to an urgent care center or the emergency room (ER). This service is available at no cost to you. Simply call the phone number on the back of your member identification card.

Right to Cancel

You may cancel this Contract within 10 days of receiving it by delivering a written notice to UCare, 500 Stinson Blvd. NE, Attn: Customer Services, Minneapolis, MN 55413. Or, you may mail a written notice to us at UCare, P.O. Box 52, Minneapolis, MN 55440-0052. This Contract must be returned before midnight the 10th day after the date you receive this Contract. The Contract will then be considered void from the beginning, and you must pay any claims incurred prior to cancellation. Notice of cancellation and return of this Contract given by mail are effective if properly addressed, postage prepaid and postmarked within the 10-day period explained above. UCare will return all premium payments made for this Contract within 10 days after receipt of notice of cancellation and the returned Contract.

Renewal

You may continue with your current plan or change coverage for the upcoming year during the annual open enrollment period. You may also be eligible for special enrollment periods under certain circumstances. See the *Changes in Coverage* section for more information.

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

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 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

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

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

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-6500/1-866-457-7144 (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 ኣማርኛ 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 ကျိာ်ဒးယိ, နမၤနှ၊် ကျိာ်ဒးတ၊်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ 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 ភាសារ៉ូឌរ, រសរាជំនួយរ័ដ្ឋកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរ៉ីអ្នក។ 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).

Dear UCare Member,

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

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

Disclosure Required By Minnesota Law

This Contract is expected to return on average 81.5% of your coverage costs for health care. The lowest percentage permitted by state law for this Contract is 80%.

Please Read Your Contract Carefully

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

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

Mark Traynor
President and Chief Executive Officer

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

Important Member Information & Member Rights and Responsibilities

MEMBER INFORMATION

1. COVERED SERVICES: Services provided by UCare will be covered at the in-network benefit level when services are provided by participating UCare providers or as authorized by UCare. Your Contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

2. PROVIDERS: Enrolling in UCare does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of UCare's network for this plan, you must choose among remaining UCare providers to receive services at the in-network benefit level.

3. EMERGENCY SERVICES: Emergency services from providers who are not affiliated with UCare will be covered. Your Contract explains the procedures and benefits associated with emergency care from UCare in-network providers and non-network providers.

4. EXCLUSIONS: Certain services or medical supplies are not covered. You should read the Contract for a detailed explanation of all exclusions.

5. CANCELLATION: Your coverage may be canceled by you or UCare only under certain conditions. Your Contract describes all reasons for cancellation of coverage.

6. NEWBORN COVERAGE: If your health plan provides for dependent coverage, a newborn infant can be covered from birth. UCare will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify MNsure and UCare of the infant's birth and that you would like coverage. If your Contract requires an additional premium for each dependent, UCare is entitled to all premiums due from the time of the infant's birth until the time you notify MNsure and UCare of the birth. UCare may withhold payment of any health benefits for the newborn infant until any premiums you owe are paid.

7. PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT: Enrolling in UCare does not guarantee that any particular prescription drug will be available or that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Contract year.

MEMBER RIGHTS AND RESPONSIBILITIES

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

1. Available and accessible services including emergency services, as defined in your Contract, 24 hours a day and seven days a week;

2. Be informed of health problems, and to receive information regarding medically necessary treatment options and risks that is sufficient to assure informed choice, regardless of cost or benefit coverage;

3. Refuse treatment, and the right to privacy of medical and financial records maintained by UCare and its health care providers, in accordance with existing law;

4. Make a complaint or appeal a coverage decision, and the right to initiate a legal proceeding when experiencing a problem with UCare or its health care providers. (See the *Appeals and Complaints* section for more information on your rights);

5. Receive information about UCare, its services, its practitioners and providers, and your rights and responsibilities;

6. Be treated with respect and recognition of your dignity and your right to privacy;

7. Participate with your providers in making health care decisions; and

8. Make recommendations regarding the organization's member rights and responsibilities policy.

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

1. Supply information (to the extent possible) that the organization and its providers need in order to provide care;

2. Follow plans and instructions for care that you have agreed to with your providers to sustain and manage your health;

3. Understand your health needs and problems, and participate in developing mutually agreed-upon treatment goals to the degree possible; and

4. Pay copayments at the time of service and to promptly pay deductibles, coinsurance and, if applicable, additional charges for non-covered services.

Important Notice from UCare About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may

consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the customer service number listed in the front cover.

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

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

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov.

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

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

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

Table of Contents

Introduction

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

This plan is subject to applicable state and federal laws and regulations.

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

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

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

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

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

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

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

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

Members are subject to all terms and conditions of this Contract and all covered health services must be medically necessary.

While you are a member of our plan, you must use your current member identification card whenever you receive covered services, including prescription drugs received at in-network pharmacies. If you do not show your current member identification card, you may be required to pay at the time you receive services or receive a bill for health services or prescription drugs.

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

Nondiscrimination Policy

UCare's nondiscrimination policy is to treat all persons alike, without distinctions based on race, color, creed, religion, national origin, gender, marital status, disability, sexual orientation, age, genetic information, public assistance status or any other classification protected by law.

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

Using Your Benefits

The services covered under this Contract are in the *Benefits Chart* section of this Contract. The *Benefits Chart* section also identifies some non-covered items. A list of general and service-specific exclusions not covered by this Contract is in the *Exclusions* section. See those sections for information on covered and non-covered services. Information on our medical policies is on our website. Visit the *About Us* section of **ucare.org** and click *Important Coverage Information*.

Each Time You Receive Covered Services

Make sure that your provider is a network provider with this plan to be eligible for in-network benefit coverage. Identify yourself as a UCare member of this plan. Show your current member identification card.

Member Identification Card

While you are a member of our plan, you must use your current member identification card whenever you access covered services, including prescription drugs received at network pharmacies. If you do not show your current identification card, you may receive a bill for health services or prescription drugs or be required to pay at the time you receive services.

We will issue you a member identification card when we receive payment for the first month's premium. If any information on your member identification card is incorrect or if you lose your card, contact Customer Services as soon as possible.

Using the Network

Important: This health plan has a specific provider network. This provider network may be different from other UCare provider networks. Be aware of your plan's provider network and use those providers to receive the highest level of benefit coverage.

In-Network Providers

Network providers are the physicians, other health care professionals, medical groups, hospitals, other facilities and pharmacies that have a contract with UCare to deliver covered health care services to members in this plan. **To get the highest level of benefits for covered services, you generally must receive covered services from an in-network provider.** There are limited exceptions as described in this Contract.

There are several ways to find the most current information about providers and their professional qualifications, such as medical school attended, residency completed and board certification status available in your network.

Find a Doctor

Visit **ucare.org** to access the *Find a Doctor* tool. This is the most current listing, which is updated daily. It allows you to search by a variety of criteria, including your location. Be sure to select UCare Choices as the health plan to identify the in-network providers for this plan.

UCare is required to update the *Find a Doctor* tool once a month. State law requires that if you receive services from an in-network provider who becomes a non-network provider before the change is posted in the *Find a Doctor* tool, we must reprocess the

claim under the in-network benefit. If UCare notified you of the provider changing from in-network to non-network in the *Find a Doctor* tool prior to you obtaining services we will process the claim under the non-network benefit.

Call us

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

Check with your provider

Physicians and other professional providers may provide certain services at non-network hospitals, surgical centers and other facilities. We recommend that you confirm with the provider that they are still within the applicable network at the time of service.

If you need emergency care, you are not required to receive services from an in-network provider or facility. For more information on coverage for emergency services, refer to the *Benefits Chart* section.

Your primary care provider may deliver, coordinate or help you access a range of health care services. To access your primary care provider, go online to their clinic's website or call the clinic. UCare's Customer Services may also be able to help you schedule appointments.

You do not need a referral to see a specialist, such as behavioral health or cardiology, in the Plan network.

Your provider will usually coordinate your hospital care and hospital admission, if needed. If you do not know which hospital your provider is associated with, contact your clinic to ask. If you have a hospital preference, check our list of network hospitals in the *Provider Directory* or on the *Find a Doctor* tool at **ucare.org**.

Non-Network Providers

The Contract also provides benefits for some covered services received from non-network providers. Non-network benefits are generally at a lower level of coverage, because these providers do not have a network contract with UCare. If you receive services from a non-network provider, you may have to pay more compared to your costs for services from an in-network provider. In addition to the non-network deductible and coinsurance described in the *Benefits Chart,* you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider. See the *Provider Payment* and *Balance Billing* sections for more details.

Direct Access Services

Some services from in-network and non-network providers are covered at the same benefit level to comply with state law. To receive those benefits, it must be for a service we cover and you may still be liable for costs above the allowed amount from the non-network provider. See the *Benefits Chart* section for details.

Emergency and Urgent Care Services

Emergency Services

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

You may get covered emergency services whenever you need them, anywhere in the United States, from an in-network or non-network provider. You can get help as quickly as possible by calling 911.

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. Emergency ambulance services are covered anywhere in the United States.

If your emergency services are provided by non-network providers, we can help arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

If you are admitted to a non-network hospital as a result of an emergency, you must notify UCare as soon as reasonably possible. Call Customer Services at one of the numbers inside the front cover of this Contract or on your member ID card.

If you are confined in a non-network hospital as a result of an emergency, your emergency coverage continues at the in-network level until it is safe to transfer you to an in-network facility.

If the services you require do not meet the definition of an emergency, refer to the *Benefits Chart* section for a description of your benefits.

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

Urgent Care

Urgent care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care, but not so severe as to require emergency services.

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

Prescription Drugs

This plan uses a prescription drug formulary. This is a list of generic and brand drugs that are covered by this plan. To be covered, the drug must be on our formulary, or a formulary exception must be obtained. The most recent formulary for this plan can be found at **ucare.org**. There is coverage for women's FDA-approved contraceptives and all FDA-approved tobacco cessation drugs, also called Nicotine Replacement Therapy (NRT).

To be covered, you must use a network pharmacy to fill your prescription. The *Provider Directory* includes in-network pharmacies. You can go online at **ucare.org** for the most current information.

In a medical emergency, we will cover prescriptions filled at a non-network pharmacy if the prescription is related to care for the emergency. In such a case, you will generally need to pay the full cost when you fill your prescription, rather than your normal share of the cost. UCare will then reimburse you for the difference paid. Call Customer Services to learn how to request reimbursement for the cost of the prescription.

The *Benefits Chart* section of this Contract includes cost-sharing information for covered drugs.

Some formulary drugs have specific requirements for coverage:

- Authorization: Some drugs require you or your provider to get approval from UCare before you fill your prescription. If you do not get approval, we may not cover the drug. The formulary states which drugs require approval or authorization.
- Step therapy: Even though the drug is on the formulary, we may require you to try one or more alternative drugs on the formulary before this drug will be covered.
- Quantity limits: We limit the amount of some covered drugs you can receive each time the prescription is filled.
- Specialty drugs: Fairview Specialty Pharmacy (Fairview) is the exclusive network provider of specialty drugs for members of this plan. Specialty drugs are costly injectable or oral drugs that often require special handling or monitoring by a trained pharmacist or nurse. If you use a specialty drug, you or your physician will need to contact the specialty pharmacy to arrange for the prescription. Your drug and any needed supplies will be shipped to your home, work or doctor's office. Fairview also provides clinical support to you and your caregivers. A Fairview pharmacist is available 24 hours a day if you have an urgent need related to your specialty drug. To contact Fairview Specialty Pharmacy, call 1-800-595-7140 toll free. TTY users may call the National Relay Center at 1-800-855-2880 and ask for 1-877-509-5114 toll free.

Mail Order Pharmacy

You can fill the prescriptions you take regularly through the Express Scripts Mail Order Pharmacy. You can order up to a 90-day supply of eligible generic and brand medications. For most generic medications, you can get a 90-day supply for the price of two copays.

To start using the Mail Order Pharmacy service:

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

For questions or assistance, please contact Express Scripts Customer Service at the numbers listed above.

Note: Specialty medications must be filled through Fairview Specialty Pharmacy. Please see the section above for more information.

Requesting a Formulary or Drug Restriction Exception

You, your designee or your provider can ask UCare to make an exception to cover a non-formulary drug or an exception to a drug restriction. Call Customer Services at the number inside the front cover for information on how to request an exception. We generally require your provider to submit a statement supporting your request.

A formulary exception may be granted when your prescriber provides an oral or written statement to UCare indicating one of the following criteria has been met: two or more of the covered drugs on the formulary (if available) for treatment of your condition would not be as effective for you as the non-formulary drug; two or more of the covered drugs on the formulary (if available) for treatment of your condition would have adverse medical effects; the formulary drug has caused an adverse reaction; the formulary drug is contraindicated; and/or the prescriber demonstrates that a prescription drug must be dispensed as written to provide maximum medical benefit to you.

Standard exception requests

You or your designee, and prescriber are notified of the determination (approval or denial) within 72 hours for a standard formulary exception request. For approved standard exception requests, the non-formulary drug will be covered for the duration of the prescription, including refills up to a maximum of one year from date of approval. If the standard exception request is denied, you have the right to request an external appeal. You or your designee, and prescriber are notified of the determination (approval or denial) within 72 hours of the request. For approved external appeal review of standard exception requests, the non-formulary drug will be covered for the duration of the prescription, including refills up to a maximum of one year from date of approval.

Expedited exception requests

An expedited exception request may be made when you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. You or your designee and prescriber are notified of the determination within 24 hours. For approved expedited requests, the non-formulary drug will be covered for the duration of health condition or course of treatment related to the expedited request up to a maximum of one year from date of approval.

If the expedited exception request is denied, you have the right to request an external appeal (see the *Appeals and Complaints* section of this Contract). You or your designee, and prescriber are notified of the determination (approval or denial) within 24 hours of the request. For approved expedited exception requests, the non-formulary drug will be covered for the duration of health condition or course of treatment related to the expedited request up to a maximum of one year from date of approval.

Authorization and Notification

For some services, we require your provider to request authorization from us ***before*** you receive those services. Those services are covered only if your provider first gets approval. There may be other services that require your provider to obtain authorization after a certain point in your therapy to continue. See the *Benefits Chart* section for information on which services require authorization.

For other services, we may require your provider to notify us within a defined period of time after the service occurs. The *Benefits Chart* section also provides information on which services require notification.

Authorization and notification are the responsibility of you and your provider. When required, authorization and notification must be obtained for services received from in-network and non-network providers. If you would like a specific list of services that require authorization or notification, please visit **ucare.org** or call Customer Services at one of the phone numbers inside the front cover.

If you have questions about the authorization or notification process, call Customer Services at one of the phone numbers inside the front cover.

Changes to these services requiring authorization or notification may occur periodically.

Continuity of Care

As a current member, you have the right to continuity of care in some situations. If we end our network relationship with your provider without cause, resulting in your provider becoming a non-network provider, you may be eligible to continue receiving care from that provider at the in-network benefit level for a reasonable period of time before transferring to an in-network provider.

Continuity of care applies only if your provider agrees to follow UCare's authorization and notification requirements, provides us with all necessary medical information related to your care, and accepts UCare's allowed amount for covered services.

You may request that we authorize continuity of care for up to 120 days for the following:

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

UCare will consider continuity of care services for up to 120 days if you request care from a current provider that was terminated, if:

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

We will not authorize continuity of care if:

- Your provider terminates its network contract with UCare
- We terminate our contractual relationship with your provider for cause

UCare will help you transition from a non-network provider to an in-network provider if you ask us. Call Customer Services at the number on the inside front cover if you have questions about continuity of care.

Important Coverage Information

When new technologies enter the marketplace (devices, procedures and drugs), UCare's medical leaders carefully evaluate them for effectiveness. We use information gathered from many sources and standard-setting organizations in our evaluation.

- UCare's clinical and quality committees and medical directors carefully research and review new technologies before determining their medical necessity and/or appropriateness.
- UCare uses information from many sources in our evaluation efforts, including the Winifred S. Hayes, Inc., Technology Assessment Reports, published peer-reviewed medical literature, consensus statements and guidelines from national medical associations and physician specialty societies, the U.S. Food and Drug Administration (FDA), other regulatory bodies, and internal and external expert sources.

- UCare's medical and coverage policies support the administration of benefits under our health plans. In the event of a conflict, the specific member contract and federal and state laws and regulatory guidance supersedes the medical policy.
- UCare encourages your doctors and health care team to talk openly with you. We do not restrict doctors from talking with you about care options, regardless of cost.

To learn about our specific medical policies, including initiating and developing medical policy requests, visit the *Medical Policies* section at **ucare.org**.

If you need care when outside of the plan's service area and it is not an emergency, we can help you find a doctor and get the care you need. UCare's nurse line is available 24 hours a day, seven days a week. Except for emergencies, most services provided outside of the UCare service area or the State of Minnesota are considered a non-network service. For these services, non-network benefits would apply. In some cases, there are authorizations and notifications required. Services outside of the United States are not covered. See the *Benefits Chart* and the *Authorization and Notification* sections in this Contract.

Note: The level of coverage may vary depending on regulations or the benefits outlined in this Contract. When the Contract does not contain information to answer your specific question, you or your doctor can contact us to start the coverage determination process.

Approved Clinical Trials

We do not (i) deny participation by members in approved clinical trials; (ii) deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the approved clinical trial; or (iii) discriminate against individuals on the basis of their participation in an approved clinical trial. Subject to the cost-sharing and other obligations explained in this Contract, this plan will cover costs associated with covered services that are related to an approved clinical trial, regardless of whether a person is in the approved clinical trial. (For example, physician visits.)

UCare reserves the right to determine whether a clinical trial is an approved clinical trial in accordance with the law. If you have questions about whether a clinical trial is an approved clinical trial, please call Customer Services.

Health Club Savings Program

For each calendar month in which you visit a participating health club 12 or more times, you will receive up to a $20 discount toward your monthly membership fees at the participating health club. Members with family coverage may add one covered dependent (must be 18 years or older) to qualify for a total credit of up to $40 per month. Credits are only provided if you are still a member at the UCare-participating health club on the date of the credit. Call Customer Services for information on participating health clubs, or visit **ucare.org**.

WholeHealth Living™

WholeHealth Living provides online access to more than 40,000 alternative medicine practitioners and discounts for popular brand-name health products. There are no referrals or pre-authorizations needed and no claims to file. The discounts can be used by simply printing a certificate from the website. Our diverse network includes acupuncture, massage, Tai Chi, nutritionists and much more. To find discounts and print certificates, access your member account at **ucare.org** > *Member Log In*. Always check your plan for covered services. These discounts are for non-covered benefits.

Cost-Sharing

When you use your UCare benefits, you may be responsible for making payments toward those services. The amount you need to pay may vary based on the services received, and whether those services were from in-network or non-network providers. See the *Benefits Chart* section for details on cost-sharing for specific benefits and the *Definitions* section for an explanation of cost-sharing.

Cost-Sharing for In-Network Providers

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

- Copayment
- Coinsurance
- Deductible

Once you have reached your in-network out-of-pocket limit for cost-sharing with in-network providers, the plan will pay 100% of the allowed amount for covered services received from in-network providers.

You will also be 100% responsible for paying for services not covered by this Contract.

Cost-Sharing for Non-Network Providers

Providers who do not have a network contract with UCare are non-network providers. Generally, you will pay more out-of-pocket when you get care outside your plan's network.

There are some exceptions (i.e., emergency services, testing and treatment of sexually transmitted diseases, and services related to conceiving and bearing children).

Generally, payments for non-network providers are based on the allowed amount (see the *Provider Payment* section to learn how this is calculated for non-network providers). While some providers may consider this payment in full, they are not required to do so. When using non-network providers, you may have to pay one or more of the following:

- Copayment
- Coinsurance
- Deductible
- Charges that exceed the allowed amount, if the provider does not accept UCare's payment as payment in full (e.g., the charges remaining after UCare has paid the allowed amount and you have paid your cost-sharing). See the *Balance Billing* and *Provider Payment* sections.

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

You will also be 100% responsible for payments to providers for services not covered by this Contract.

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

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

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

Out-of-Pocket Limit

Out-of-pocket limit is the maximum amount you have to pay out-of-pocket for in-network copayments, coinsurance and deductibles for covered services received during a calendar year. After you have reached your plan's individual or family out-of-pocket limit, the plan pays 100% of the cost for in-network covered services for the remainder of the year. The amounts you pay for copayments and coinsurance for in-network covered services count toward your out-of-pocket limit. Amounts you pay for plan premiums, balance-billed charges from non-network services and health care services not covered by this plan, are not included in the out-of-pocket limit. Any amount you pay for non-covered charges does not apply toward your out-of-pocket limit.

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

For information on how we help you keep track of your out-of-pocket limit, call Customer Services at the number inside the front cover.

Balance Billing

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

This plan's in-network providers are not allowed to bill you for any amount that exceeds the cost of UCare's allowed amount. However, an in-network provider **is** permitted to bill you for any cost-sharing including copayment, deductible or coinsurance.

Embedded Deductible and Out-of-Pocket Limit

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

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

Provider Payment

This section describes how we generally pay providers for health services, and your responsibility for provider payments.

In-Network Providers

In-network providers are paid according to the terms of their agreement with UCare. Payment terms may differ by plan. Payment methods are intended to promote efficient and effective delivery of health care. They are not intended to affect your access to health care. Payment methods may include, but are not limited to: payments based on the type or quantity of services received (fee-for-service); or a fee for a particular episode of care or health event.

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

Fee-for-service payment means that UCare pays the in-network provider a fee for each service provided, based on a defined fee schedule. Under this arrangement, network providers typically receive a payment amount that is less than what they would have otherwise billed. The fee amount may be a set percentage of the in-network provider's charge. The amount paid to the in-network provider, less any copayment, coinsurance or deductible, is considered to be payment in full. Members are not responsible for any difference between these payments and the provider's billed charges.

Non-Network Providers

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

Except in certain cases, such as emergency non-network care, your out-of-pocket costs related to non-network provider services will not count toward your out-of-pocket limit. Your benefit coverage is also less comprehensive when using non-network providers.

Benefits Chart

On this *Benefits Chart*, all cost-sharing amounts are calculated based upon UCare's allowed amount. As explained in the *Provider Payment* section, you are responsible for paying any difference between the allowed amount and a provider's billed charges for non-network provider services (unless an exception applies).

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
DEDUCTIBLE		
Single coverage/family coverage. The family deductible is embedded. (See the *Definitions* section for an explanation of embedded deductible.)	$2,900/$5,800	$5,800/$11,600
OUT-OF-POCKET LIMIT		
Single coverage/family coverage. The family out-of-pocket limit is embedded. (See the *Definitions* section for an explanation.)	$7,000/$14,000	No limit.
AMBULANCE - EMERGENCY TRANSPORTATION		
We cover ambulance and medical transportation for medical emergencies.	You pay 25% after the in-network deductible has been met.	You pay 25% after the **in-network** deductible has been met.
AMBULANCE - NON-EMERGENCY MEDICAL TRANSPORTATION		
Transfers between network hospitals for treatment by network physicians are covered, if initiated by a network physician. Transfers from a hospital or to home/other facilities are covered if medical supervision is required en route.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
CHIROPRACTIC CARE		
We cover chiropractic services including office visits for rehabilitative care, provided to diagnose and treat (by manual manipulation or certain therapies) acute conditions related to the muscles, skeleton and nerves of the body. Common conditions are low back pain, headache and neck discomfort. Office visits include medical history; medical examination; medical decision making; counseling; coordination of care; nature of presenting problem; and chiropractor's time. Massage therapy performed with other treatment/ modalities by a chiropractor, as part of a prescribed treatment plan and is not billed separately, is covered.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). For subsequent visits, you pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Services not covered include: • Acupuncture • Massage for the purpose of comfort or convenience of the member, or related to therapeutic massage • Treatment when there is no significant, measurable or quantifiable progress over a certain period of time		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
DENTAL - ACCIDENTAL/MEDICAL		
This plan does not cover comprehensive dental services. Only the following services are covered: 1. Accidental Dental Services: We cover dental services necessary to treat and restore damage done to sound, natural, unrestored teeth as a result of an accidental injury. Coverage is for damage caused by external trauma to the face and mouth only, not for cracked or broken teeth that result from biting or chewing. Coverage includes the following procedures directly related to the accident: • Initial exam and x-rays • Restorations • Root canals • Crowns • Surgical procedures and extraction 2. Medical Referral Dental Services. a. Medically Necessary Outpatient Dental Services: We cover medically necessary outpatient dental services. Coverage is limited to dental services required to treat an underlying medical condition, e.g., removal of teeth to complete radiation treatment for cancer of the jaw, cysts and lesions. b. Medically Necessary Hospitalization and Anesthesia for Dental Care: We cover medically necessary hospitalization for dental care. This is limited to charges incurred by a member who: (i) is a child under age 5; (ii) is severely disabled and is determined by a physician to be unable to cooperate with dental care under local anesthesia; (iii) has a medical condition, and requires hospitalization or general anesthesia for dental care treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist professional fees are **not** covered.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
3. Oral Surgery: We cover the following oral surgery which is medically necessary. Coverage is limited to treatment of medical conditions requiring oral surgery, such as oral neoplasm, non-dental cysts, fracture of the jaws and trauma of the mouth and jaws. 4. Treatment of Cleft Lip and Cleft Palate: We cover treatment of cleft lip and cleft palate of a dependent child, to the limiting age in the definition of an "Eligible Dependent." Coverage includes orthodontic treatment and oral surgery directly related to the cleft. Benefits for eligible dependents age 19 and older are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or begun prior to the dependent turning age 19. We do **not** cover dental services unless they are determined to be required to treat cleft lip or cleft palate. If a dependent child covered under this Contract is also covered under a dental plan that includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services. Oral appliances are subject to the same copayment conditions and limits as durable medical equipment. 5. Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD): We cover medically necessary surgical and non-surgical treatment of temporomandibular disorder (TMD) and craniomandibular disorder (CMD).		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Services not covered include: • Oral surgery/extraction to remove wisdom teeth • Treatment of cracked or broken teeth as a result of biting or chewing • Accident-related dental services if treatment is (i) provided to teeth that are not sound and natural, (ii) to teeth that have been restored, (iii) initiated beyond six months from the date of the injury, (iv) received beyond the initial treatment or restoration, or (v) received beyond 24 months from the date of injury • Dental implants (tooth replacement) • Osteotomies and other procedures associated with the fitting of dentures or dental implants • Orthognathic treatment • Procedures that are of dental or cosmetic in nature • Dental treatment, procedures and services not listed in this Contract		
DENTAL – PEDIATRIC BASIC/MAJOR CARE		
The following pediatric dental services are covered for members under age 19. Restorative services include: • Amalgam and resin-based composite filings • Root canal • Extractions • Periodontal scaling and root planing once every 24 months • Full mouth debridement once per lifetime • Crowns – limited to one per tooth, per 60 months • Some inlays and onlays - one per tooth, per 60 months • Complete and partial dentures, bridges – limited to one in a 60-month period, adjustments, repairs, relines and rebases, every 36 months • Some complex oral surgery • Implants - one every 60 month	You pay 25% after the in-network deductible has been met.	Not covered.
The following dental services are not covered: • Services from non-network providers • Dental services for members age 19 and older • TMJ-related services • Temporary services (e.g., provisional crowns, interim dentures)		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
DENTAL – PEDIATRIC CHECK-UP		
These pediatric dental services are covered for members under age 19: • Periodic oral evaluation – one every six months • Limited oral evaluation – one every six months • Comprehensive oral evaluation – one every six months • Comprehensive periodontal evaluation – one every six months • Intraoral – complete series (including bitewings) – one every 60 months • Intraoral – periapical and occlusal film • Bitewings – one set every six months • Vertical bitewings – seven to eight films – one set every six months • Panoramic film – one film every 60 months • Cephalometric radiographic image • Oral / Facial photographic images • Interpretation of diagnostic image • Diagnostic models • Prophylaxis – one every six months • Topical application of fluoride (excluding prophylaxis) – two every 12 months • Sealant – per tooth – unrestored permanent molars – one sealant per tooth every 36 months • Space maintainers – fixed and removable – unilateral and bilateral • Re-cementation of space maintainer	You pay nothing.	You pay 50% after the non-network deductible has been met.
DIABETES EDUCATION		
We cover education for preventive services and education to help manage chronic health conditions, including diabetes.	You pay nothing.	You pay 50% after the non-network deductible has been met.
DRUGS – BRAND AND GENERIC		
Brand We cover formulary brand prescription drugs.	You pay 40% after the in-network deductible has been met.	Prescription drugs from a non-network pharmacy are not covered.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Generic We cover formulary generic prescription drugs. Select generic drugs may be covered at the brand benefit level if it is indicated on the formulary.	You pay $12 copayment. $24 for up to 90-day extended supply at a participating in-network retail or mail order pharmacy.	Prescription drugs from a non-network pharmacy are not covered.
More Drug Coverage Information Over-the-counter drugs are generally not covered, except for medications covered as part of the Essential Health Benefits. These include but are not limited to emergency contraception, tobacco cessation and diabetic supplies. Over-the-counter drugs must be prescribed and on our formulary to be covered. Diabetic supplies and equipment are limited to certain models and brands (see UCare's formulary and the *Preventive Care/Screening/Immunization* section of the *Benefits Chart*). We cover women's FDA-approved contraceptives received at a pharmacy (see UCare's formulary and the *Preventive Care/Screening/Immunization* section of the *Benefits Chart*). We cover all FDA-approved tobacco cessation drugs, also called Nicotine Replacement Therapy (NRT), which are covered as: • Tobacco cessation drugs obtained with a prescription: no charge at in-network pharmacy • Over-the-counter tobacco cessation drugs: no charge through our Tobacco Cessation Program (see the *Preventive Care/Screening/Immunization* section of the *Benefits Chart*) Authorization may be required. See the *Authorization and Notification* section of this Contract.		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Prescription drugs and medications not covered include: • Non-formulary brand and generic drugs, unless an exception is granted • Drugs used for weight loss • Drugs used for cosmetic purposes • Replacement of prescription drugs, medications, equipment and supplies due to loss, damage or theft • Non-prescription (over-the-counter) drugs or medications, unless listed on the formulary. This includes, but is not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs. See *More Drug Coverage Information* for additional information related to prescribed over-the-counter coverage. • All drugs used to treat sexual dysfunction • All drugs used to treat infertility		
DRUGS - SPECIALTY		
We cover formulary generic and brand specialty drugs. If you would like the Specialty Pharmacy Drug List, please visit **ucare.org** or call Customer Services at the phone number listed inside the front cover. Fairview Specialty Pharmacy is the exclusive network provider of specialty drugs for plan members. Specialty drugs are costly injectable or oral drugs. They often require special handling or monitoring by a trained pharmacist or nurse. If you use a specialty drug, Fairview Specialty Pharmacy will work with you and your provider to access needed clinical support. Authorization may be required. See the *Authorization and Notification* section of this Contract.	You pay 40% after the in-network deductible has been met.	Speciality drugs from a non-network pharmacy are not covered.
Specialty drugs not covered include non-formulary specialty drugs, unless an exception is granted.		
Notice regarding the use of manufacturer savings cards, coupons or rebates UCare and Fairview Specialty Pharmacy welcome the use of drug manufacturer savings cards, coupons or rebates to help pay the cost of specialty drugs. However, only the amount you pay out-of-pocket for your specialty drug will apply to your plan deductible and/or out-of-pocket limit. Savings card, coupon or rebate dollar amounts will not count toward your plan deductible and/or out-of-pocket limit. This ensures that you receive credit for what you have actually paid out-of-pocket, not the amount a manufacturer has contributed toward your specialty drug purchase. If you have questions, please call Customer Services.		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND MEDICAL SUPPLIES		
We cover equipment and services, as described below. • Diabetic supplies and equipment for members with gestational, Type I or Type II diabetes: 1. Glucose monitors, insulin pumps, syringes, blood and urine test strips and other diabetic supplies as medically appropriate and necessary. 2. One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two extra pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Special dietary treatment for Phenylketonuria (PKU) and oral amino acid-based elemental formula if it meets our medical coverage criteria. • External hearing aids (including osseointegrated or bone anchored aids) for members age 18 or younger with a hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid for each ear every three years. • Total parenteral nutrition/intravenous (TPN/IV) therapy, equipment, supplies and drugs in connection with IV therapy, IV line care kits. • Wheelchairs, ventilators, oxygen, oxygen equipment, continuous positive airway pressure (CPAP) devices and hospital beds. • Repair, replacement or revision of durable medical equipment due to normal wear and use. • Medical supplies, including splints, surgical stockings, casts and dressings. • Enteral feedings prescribed by a physician, physician's assistant or nurse practitioner, and are required to sustain life.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met. No coverage for hearing aids.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
• Blood, blood plasma and blood clotting factors. • Prosthetics, including artificial limbs and artificial eyes. See the *Reconstructive Surgery Due to Cancer* section for breast prosthesis coverage. • Scalp hair prostheses (wigs) for hair loss due to alopecia areata only. Maximum of one prosthesis per person per calendar year. Coverage of durable medical equipment is **limited** by the following: Payment will not exceed the cost of an alternate piece of equipment or service that is effective and medically necessary. For prosthetic benefits, other than hair prostheses (i.e., wigs) for hair loss resulting from alopecia areata and oral appliances for cleft lip and cleft palate, payment will not exceed the cost of an alternate piece or equipment or service that is effective, medically necessary and enables members to conduct standard activities of daily living. We have the right to determine if an item will be approved for rental versus purchase. Durable medical equipment and supplies must be obtained from or repaired by approved vendors. Covered services and supplies are based on established medical polices, which are subject to periodic review and modification by the medical or dental directors. Authorizations may be required. See the *Authorization and Notification* section in this Contract.		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Services not covered include, but are not limited to: • Replacement or repair of any covered items, if the items are (i) damaged or destroyed by member misuse, abuse or carelessness, (ii) lost, or (iii) stolen • Duplicate or similar items • Labor and related charges for repair of any covered items that exceed the cost of replacement by an approved vendor • Sales tax, mailing, delivery charges and service call charges • Items that are primarily educational in nature or for hygiene, vocation, comfort, convenience or recreation • Communication aids and devices: equipment to create, replace or augment communication abilities including, but not limited to hearing aids (implantable and external, including osseointegrated or bone anchored) and fitting of hearing aids for adults, except as required by law, speech processors, receivers, communication boards or computer or electronic assisted communication, except as described in this Contract • Household equipment that primarily has customary use other than medical, such as, but not limited to exercise cycles, air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses and waterbeds • Household fixtures including, but not limited to escalators or elevators, ramps, swimming pools and saunas • Changes to the structure of the home including, but not limited to its wiring, plumbing, or charges to install equipment • Vehicle, car or van modifications including, but not limited to hand brakes, hydraulic lifts and car carrier • Rental equipment while your own equipment is being repaired by non-contracted vendors, beyond a one-month rental of medically necessary equipment • Other equipment and supplies, including but not limited to assistive devices that we determine are not eligible for coverage • Hearing aids and their fitting, except as specifically described in this Contract. This exclusion does not apply to cochlear implants, which are covered as described in the medical coverage criteria. • Hearing aid batteries • Over-the-counter orthotics and appliances		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
EMERGENCY ROOM SERVICES		
Emergency services include the evaluation of an illness, injury, symptom or condition so serious, including severe pain, that a reasonable person would seek care right away to avoid severe harm, and seek treatment to stop the illness, injury, symptom, or condition from getting worse. Emergency care includes services required to treat: (i) the sudden, unexpected onset of illness or injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization, or (ii) a condition requiring professional health services immediately necessary to preserve life or stabilize health. You must notify UCare of emergency inpatient services as soon as reasonably possible after receiving those services. Call Customer Services at one of the telephone numbers inside the front cover. If you are confined in a non-network facility as a result of an emergency, your emergency coverage continues until your attending physician agrees it is safe to transfer you to a network facility. If the health services that you require do not meet the definition of emergency, you should refer to the most specific section of your *Benefits Chart* for a description of your benefits. To be eligible for in-network benefits after an emergency, follow-up care or scheduled care must be received from an in-network provider.	For the first emergency room visit, you pay $250 copay. For subsequent visits, you pay 25% after the in-network deductible has been met.	For the first emergency room visit, you pay $250 copay. For subsequent visits, you pay 25% after the **in-network** deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
EYEWEAR FOR CHILDREN		
This plan covers the following medically necessary vision services for members under the age of 19: We cover one pair of medically necessary eyewear (frame and lenses) each calendar year. This includes polycarbonate lenses with scratch coating. In lieu of medically necessary eyeglasses, we cover one pair of conventional contact lenses, or one 12-month series of planned replacement lenses per calendar year to correct visual acuity limitations. This includes lens fitting and exam. Coverage is limited to the most cost-effective and medically necessary alternative. When you purchase lenses, frames or optical devices that are more expensive than what is considered medically necessary by UCare's medical director or its designee, you are responsible for paying the difference in purchase and maintenance cost.	You pay 25% after the in-network deductible has been met. Limit of one item per calendar year.	Not covered.

Services not covered include:

- Eyeglasses and contacts for members age 19 and older, except as described in the *Vision* section of the *Benefits Chart*
- Safety glasses or goggles for sports or vocational reasons
- Color contact lenses
- Daily wear specialty contact lenses
- Protective coating for plastic lenses
- Contact lenses supplies
- Services and materials not meeting the standards of accepted optometric practices
- Repairs to frames and lenses
- Replacement of stolen, broken or lost eyewear
- Replacement of lenses or frames due to provider error in prescribing, frame selection or measurement. The provider making the error is responsible for the cost of correcting the error.
- Non-prescription lenses, including reading glasses
- Two pairs of eyeglasses in lieu of bifocals
- Contact lens insurance
- Sunglasses, sport lenses and sport frames
- Refractive eye surgery
- Special lens designs and coatings not medically necessary, including but not limited to special lenses or lens modifications that do not correct visual acuity problems, tinted lenses, transition (photochromic) lenses, high-index lenses, progressive or invisible lenses, ultraviolet coating, and photochromic and non-reflective coating

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
HOME HEALTH CARE SERVICES		
We cover skilled nursing services, physical therapy, occupational therapy, speech therapy, respiratory therapy and other therapeutic services, prenatal and postnatal services, child health supervision services, phototherapy services for newborns, home health aide services, and other eligible home health services when provided in the member's home, if the member is homebound (i.e., unable to leave home without considerable effort due to a medical condition). Lack of transportation does not constitute homebound status. Phototherapy services for newborns and high-risk prenatal services, supplies and equipment are covered. We cover total parenteral nutrition/intravenous (TPN/IV) therapy, equipment supplies and drugs in connection with IV therapy. IV line care kits are covered under *Durable Medical Equipment*. We cover palliative care benefits. Palliative care includes managing symptoms, education and establishing care goals. We waive the requirement that you be homebound for a limited number of palliative care home visits, if you have a life-threatening, non-curable condition with a prognosis of two years or less. Additional palliative care visits are eligible under the home health services benefit if you are homebound and meet all other requirements defined in this section. You do not need to be homebound to receive total parenteral nutrition/intravenous (TPN/ IV) therapy.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Home health services are eligible and covered only when they are: 1. Medically necessary 2. Provided as rehabilitative or habilitative care, terminal care or maternity care 3. Ordered by a physician, and included in the written home care plan Home health services are **not** provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home. We will **not** reimburse family members or residents in the member's home for the above services. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. When a service (e.g., tracheotomy suctioning or ventilator monitoring) can be safely and effectively performed by a non-medical person (or self-administered) without the direct supervision of a licensed nurse, the service shall **not** be regarded as a skilled nursing service, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service does **not** make it a skilled service when a skilled nurse provides it. Only the skilled nursing components of so-called "blended" services (i.e., services that include skilled and non-skilled components) are covered under this Contract. Home Health Care services are limited to 120 visits per year. Authorization required. See the *Authorization and Notification* section in this Contract.		
Services not covered include: • Charges for elective home births • Rest and respite services for caregivers, except as respite services are specifically described		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
HOME HOSPICE SERVICES		
These definitions apply: Part-time. This is up to two hours of service per day; more than two hours is considered continuous care. Continuous care. This is from two to 12 hours of service per day provided by a registered nurse, licensed practical nurse or home health aide, during a period of crisis in order to maintain a terminally ill patient at home. Appropriate facility. This is a nursing home, hospice residence or other inpatient facility. Custodial care related to hospice services. This means assisting in the activities of daily living and the care needed by a terminally ill patient that can be provided by a primary caregiver (i.e., family member or friend) who is responsible for the patient's home care. We cover the services described below for members who are terminally ill patients and accepted as home hospice program participants. Members must meet the program eligibility requirements, and choose to receive services through the hospice program. The services will be provided in the patient's home, with inpatient care available when medically necessary as described below. Members who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the home hospice program.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
1. Eligibility. In order to be eligible for the home hospice program, a member must: (i) be a terminally ill patient (prognosis of six months or less); (i) have chosen a palliative treatment focus (i.e., emphasizing comfort and support services rather than treatment attempting to cure the disease or condition); and (iii) continue to meet the terminally ill prognosis. A member may withdraw from the home hospice program at any time. 2. Eligible services. Hospice services include the following services, if provided in accordance with an approved hospice treatment. a. Home health services: i. We cover part-time care provided in the member's home by an interdisciplinary hospice team (which may include a physician, nurse, social worker and spiritual counselor) and medically necessary home health services. ii. We will cover one or more periods of continuous care in the member's home or in a setting that provides day care for pain or symptom management, when medically necessary. b. Inpatient services: We cover medically necessary inpatient services.		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
c. Other covered services include: i. Respite care in the member's home or in an appropriate facility, to give the patient's primary caregivers (i.e., family members or friends) rest and/or relief when necessary to maintain a terminally ill patient at home ii. Medically necessary drugs for pain and symptom management iii. Semi-electric hospital beds and other durable medical equipment iv. Emergency and non-emergency care Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days per episode.		
Services not covered include: • Financial and legal counseling services • Housekeeping and meal services in the patient's home • Custodial care related to hospice services, whether provided in the home or in a nursing home • Any services not specifically described as covered services under this home hospice services benefit • Any services provided by members of the patient's family or residents in the member's home		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
INFERTILITY DIAGNOSIS		
We cover services to diagnose infertility. These services include diagnostic procedures and tests in connection with an infertility evaluation, office visits and consultations to diagnose infertility. Some services received during an office visit may be covered under another benefit within the Contract (e.g., diagnostic tests). The most appropriate benefit in the Contract will apply for each service received during an office visit.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). For subsequent visits, you pay 25% after the in-network deductible has been met. Labs and testing: You pay 25% after the in-network deductible has been met.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). For subsequent visits, you pay 25% after the **in-network** deductible has been met. Labs and testing: You pay 25% after the **in-network** deductible has been met.
We do not cover these services: • Infertility treatment • Reversal of sterilization, assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; treatment of infertility, including but not limited to office visits, laboratory and diagnostic imaging services; surrogate pregnancy and related obstetric/maternity benefits; and sperm, ova or embryo acquisition, retrieval or storage • All drugs used to treat infertility		
INJECTIONS AND IN-OFFICE TREATMENTS		
We cover injections, including allergy injections, and other treatments administered in the physician's office. Some vaccines and immunizations are considered preventive and would be covered under the *Preventive Care/Screening/Immunization* section of this Contract.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
INPATIENT HOSPITAL SERVICES		
UCare requires hospitals and providers to notify us of all inpatient, AIR (acute inpatient rehabilitation), LTAC (long-term acute care) admissions and other acute care / medical / surgical admissions before admission, and as requested for extensions. We cover the following medical and surgical services, for the treatment of acute illness or injury that require the level of care provided only in an acute care facility. Inpatient hospital services include: • Room and board • Use of operating or maternity delivery rooms • Intensive care facilities • Newborn nursery facilities • General nursing care • Anesthesia • Laboratory and diagnostic imaging services • Radiation therapy • Physical therapy • Prescription drugs and other medications administered during treatment • Blood and blood products (unless replaced), and blood derivatives • Other diagnostic and treatment-related hospital services • Physician and other medical and surgical services provided while in the hospital Notifications are required. See the *Authorization and Notification* section in this Contract.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Inpatient services not covered include items for personal convenience. See *Exclusions – Services Not Covered*.		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
INPATIENT HOSPITAL SERVICES - MATERNITY CARE		
Inpatient hospital services include: room and board; the use of operating or maternity delivery rooms; intensive care facilities; newborn nursery facilities; general nursing care; anesthesia; laboratory and diagnostic imaging services; radiation therapy; physical therapy; prescription drugs and other medications administered during treatment; blood and blood products (unless replaced), and blood derivatives; and other diagnostic or treatment-related hospital services; and physician and other professional medical and surgical services provided while in the hospital. Following a vaginal delivery, we cover a minimum of 48 hours of inpatient care for the mother and newborn child. Following a caesarean section delivery, we cover a minimum of 96 hours of inpatient care for the mother and newborn child. If the duration of inpatient care is less than these minimums, we also cover a minimum of one home visit by a registered nurse for post-delivery care, within four days of discharge of the mother and newborn child. Services provided by the registered nurse include, but are not limited to: parent education; assistance and training in breast and bottle feeding; and any necessary and appropriate clinical tests. We will **not** provide any compensation or other non-medical incentives to encourage a mother and newborn to leave inpatient care before the minimum duration times specified. Services for items for personal convenience, such as television rental, are **not** covered.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Notifications are required. See the *Authorization and Notification* section in this Contract.		
Services not covered include: • Health care professional services for maternity labor/delivery in the home • Services from a doula • Childbirth and other educational classes • Services for or related to adoption fees • Services for or related to surrogate pregnancy, including diagnostic screening, physician services, reproduction treatments, prenatal/delivery/postnatal services • Services for or related to preservation, storage and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue, except as specified in this *Benefits Chart* • Private duty nursing services. This exclusion does not apply if the covered person is also covered under Medical Assistance. • Charges for elective home births • Services for items for personal convenience		
LABORATORY SERVICES		
We cover medically necessary laboratory tests, when ordered by a provider and conducted in a clinic or outpatient hospital facility.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
MENTAL/BEHAVIORAL HEALTH INPATIENT SERVICES		
Inpatient services in a hospital and professional services to treat mental health disorders are covered when they are medically necessary. Medical stabilization is covered under inpatient hospital services in the *Inpatient Hospital Services* and *Skilled Nursing Facility Services* sections. We cover residential care to treat eating disorders in a licensed facility, as an alternative to inpatient care when it is medically necessary. We also cover medically necessary psychiatric residential treatment for emotionally handicapped children as diagnosed by a physician. The child must be under 18 years of age and an eligible dependent according to the terms of this Contract. Notifications are required and authorizations may be required. See the *Authorization and Notification* section in this Contract.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Services not covered under this benefit include: • Shelter services, correctional services, detention services, transitional services, group residential services, foster care services and wilderness programs • Court-ordered treatment, except as described under sections *Office Visits* or *Mental/Behavioral Health Office Visits* or as otherwise required by law • Professional services associated with substance abuse intervention. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this Contract to seek substance abuse treatment.		

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

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
MENTAL/BEHAVIORAL HEALTH INTENSIVE OUTPATIENT SERVICES		
Services we cover for a diagnosed mental health condition include: • Psychological testing for the purposes of determining the differential diagnoses and treatment planning for patients currently receiving behavioral health services • Day treatment in a licensed program • Partial hospitalization services in a licensed hospital or community mental health center If we or a participating provider determines that no structured treatment is necessary, members are entitled to a second opinion by a health care professional not affiliated with UCare who is qualified to diagnose and treat the condition. We will consider the second opinion, but are not obligated to accept the conclusion of the second opinion. There is no cost to the member for this second opinion. Authorizations or notifications may be required for select services. See the *Authorization and Notification* section in this Contract.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
MENTAL/BEHAVIORAL HEALTH OFFICE VISITS		
We cover services for mental health diagnoses that lead to significant disruption of function in the member's life, as described in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5). We also cover mental health treatment ordered by a Minnesota court under a valid court order based on a behavioral care evaluation by a licensed psychiatrist or doctoral-level licensed psychologist. The evaluation must include a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We must be given a copy of the court order and the behavioral care evaluation. The service must be a covered benefit under this plan, and the service must be provided by a network provider, or other provider as required by law. We cover the evaluation upon which the court order was based if it was conducted by a network provider. We also provide coverage for the initial mental health evaluation of a child, regardless of whether that evaluation leads to a court order for treatment, if the evaluation is ordered by a Minnesota juvenile court. We cover outpatient professional mental health services for evaluation, crisis intervention and treatment of mental health disorders. A comprehensive diagnostic assessment of each patient will be the basis for a determination by a mental health professional concerning the appropriate treatment and the extent of services required.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). For subsequent visits, you pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
If we or a participating provider determines that no structured treatment is necessary, you are entitled to a second opinion by a health care professional not affiliated with UCare who is qualified to diagnose and treat the condition. We will consider the second opinion, but are not obligated to accept the conclusion of the second opinion. There is no cost to you for this second opinion. Outpatient services covered for a diagnosed mental health condition include: • Individual, group, family and multi-family therapy • Medical management provided by a physician, certified nurse practitioner or physician's assistant • Psychotherapy and nursing services provided in the home Authorizations may be required. See the *Authorization and Notification* section in this Contract.		
Behavioral health services not covered include: • Intensive behavioral therapy programs for the treatment of autism spectrum disorders, including Applied Behavioral Analysis Therapy (ABA), Intensive Early Intervention Behavioral Therapy (IEIBT) and Lovaas • Religious counseling, marital/relationship counseling and sex therapy		
OFFICE VISITS		
We cover medically necessary professional services from physicians and other health care providers when delivered in an office setting. Some services or drugs received during an office visit may be covered under another benefit within this Contract (e.g., diagnostic tests, injections). The most appropriate benefit in this Contract will apply for each service received during an office visit. We cover interactive audio visual telemedicine services as an alternative to an office visit. We also cover the initial physical evaluation of a child if it is ordered by a Minnesota juvenile court.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits. For subsequent visits, you pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Eligible office visits include: • Primary care visits • Specialist visits • Urgent care visits • Behavioral health – mental health visits • Behavioral health – chemical dependency visits • Other practitioner office visits (nurse, physician assistant) • Physical therapy services • Occupational therapy services • Speech therapy services • Chiropractic services		
The following types of services are not included in the office visit benefit: • Dental services • Home health services • Home hospice services **Note:** This benefit does not include facility or hospital fees received from locations using hospital-based billing practices. See the *Outpatient Facility (e.g., Ambulatory Surgery Center) and Outpatient Surgery Physician Services* section of the *Benefits Chart*. If you are unsure if your provider uses these billing practices, contact them.		
ONLINE VISITS (E-VISITS)		
E-visits or online evaluation and management services (via the Internet or other similar secure network) provided by a physician, nurse practitioner or other eligible provider.	You pay nothing (unlimited visits).	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
ORTHODONTIA – CHILD		
The following pediatric dental services are covered for members under age 19: Orthodontics used to help restore oral structures to health and function, and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/ mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.	You pay 25% after the in-network deductible has been met.	Not covered.
The following dental services are not covered: • Services from non-network providers • Cosmetic orthodontics • Dental services for members age 19 and older		
OUTPATIENT FACILITY (E.G., AMBULATORY SURGERY CENTER) AND OUTPATIENT SURGERY PHYSICIAN SERVICES		
We cover the following medical and surgical services to diagnose or treat an illness or injury on an outpatient basis when delivered at an outpatient hospital, ambulatory care or surgical facility. We cover facility fees or hospital fees when care is provided at a hospital-based clinic. Covered outpatient services include: use of operating rooms, maternity delivery rooms and other outpatient departments, rooms or facilities; general nursing care, anesthesia, laboratory and diagnostic imaging services, radiation therapy, physical therapy, drugs given during treatment, blood and blood products (unless replaced) and blood derivatives, and other diagnostic or treatment-related outpatient services; physician and other professional medical and surgical services provided while an outpatient.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY		
We cover the following physical therapy, occupational therapy and speech therapy services: 1. Rehabilitative care to correct the effects of illness or injury 2. Habilitative care rendered for congenital, developmental or medical conditions that have significantly limited the successful initiation of normal speech and normal motor development We cover massage therapy when performed with other treatment/modalities by a physical or occupational therapist as part of a prescribed treatment plan, and is not billed separately. Authorization required. See the *Authorization and Notification* section in this Contract.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). For subsequent visits, you pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
These physical therapy, occupational therapy and speech therapy services are not covered: • Vocational rehabilitation and recreational or educational therapy. Recreation therapy is therapy provided solely for the purpose of recreation, including but not limited to: (i) requests for physical therapy or occupational therapy to improve athletic ability, and (ii) braces or guards to prevent sports injuries.		
PORT WINE STAIN REMOVAL SERVICES		
We cover port wine stain removal services.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
PREVENTIVE CARE/SCREENING/IMMUNIZATION		
We cover preventive services that meet the requirements for coverage under federal law. Preventive health services include screening tests (to detect conditions that have not been diagnosed and have not produced symptoms), preventive checkups and preventive counseling. Preventive benefits required under federal law are subject to periodic review and modification. Coverage may also change for specific ages or gender, as defined by the agencies noted below. UCare will modify coverage to reflect those changes.	You pay nothing.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Preventive services include: • Items or services that have an A or B rating in the current recommendations of the United States Preventive Services Task Force (USPSTF) – Routine health exams and health assessments. A physician or health care provider will counsel members on how often health assessments are needed based on their age, sex and health status. – Routine screening procedures for cancer • BRCA-related cancer risk assessment. If positive, genetic counseling and genetic testing for women who have family members with breast, ovarian, tubal or peritoneal cancer • Breast cancer screening (mammogram) • Cervical cancer screening • Colorectal cancer screening • Lung cancer screening in adults, ages 55-80 with a history of smoking • Prostate cancer screening (digital rectal exam only)		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
– Certain routine laboratory tests, pathology and radiology (when performed for screening purposes) • Abdominal aortic aneurysm screening in men • Abnormal blood glucose and Type 2 diabetes mellitus screening • Chlamydia and gonorrhea screening for women • Gestational diabetes screening in asymptomatic pregnant women after 24 weeks gestation • Hepatitis B in pregnant women or adults at high risk • Hepatitis C for adults at high risk • HIV screening for adolescents, adults and pregnant women • Latent TB screening in adults at increased risk • Osteoporosis screening for women ages 65 and older • RhD incompatibility screening for pregnant women • Syphilis screening for non-pregnant adolescents and adults at high risk • Universal lipids screening – Counseling/ guidance/interventions that reduce risk factors • Alcohol misuse screening and behavioral counseling interventions • Depression screening • Healthy diet and physical activity counseling for adults who are overweight and have other cardiovascular risk factors • Obesity screening and management • Sexually transmitted infections counseling • Skin cancer counseling • Tobacco cessation services and related drugs. Coverage includes at least four counseling sessions without authorization and all FDA-approved tobacco cessation drugs.		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
– Preventive medications • Aspirin to prevent cardiovascular disease and colorectal cancer • Low-dose aspirin for pregnant women at increased risk for preeclampsia • Breast cancer risk-reducing medications • Folic acid • Statins for primary prevention of cardiovascular disease • Preventive care and screenings for women, including pregnant women, based on comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) – Breast cancer screening – Breastfeeding services and supplies – Cervical cancer screening – Screening for gestational diabetes – Screening for HIV – Screening for interpersonal and domestic violence – Routine prenatal care and exams including visit-specific screening tests, education and counseling • Coverage includes one standard routine ultrasound per pregnancy		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
– Routine postnatal care and exams including health exams, assessments, education and counseling immediately following childbirth – Counseling for sexually transmitted infections – Human papillomavirus (HPV) testing – Women's FDA-approved contraceptives received at a pharmacy or contraception services administered in a provider's office, including patient education and counseling. Coverage for at least one form of contraception in each of these methods. • Sterilization surgery for women **Note:** Not covered under this section of the Contract are: • Hysterectomies • Anesthesia and facility services related to sterilization procedures performed during other surgical procedures such as Caesarean section birth, gall bladder removal and abdominal hernia repair • Surgical sterilization via implant • Implantable rods • IUD with copper • IUD with progestin • Shot/injection • Oral contraceptives (combined pill) • Oral contraceptives (progestin only) • Oral contraceptives (extended/continuous use) • Patch • Vaginal contraceptive rings • Diaphragms • Sponges • Cervical caps • Female condoms • Spermicides • Emergency contraception (Plan B / Plan B One Step / Next Choice)		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
If a provider recommends a non-covered female contraception method, prior authorization is required. It is via the prior authorization process that the attending provider communicates the nature of the medical necessity. Female contraceptive methods approved for coverage through the prior authorization process will be subject to the appropriate brand or generic drug member cost share amount when dispensed at an in-network pharmacy. If the drug is approved under the Copayment Review process, the drug's cost sharing amount will be $0. Call Customer Services at the phone number inside the front cover for more information about this process. Based on federal guidelines, UCare will defer to the decision of the provider regarding medical necessity, which may consider severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service. • Routine immunizations for children, adolescents and adults that are recommended from the Advisory Committee on Immunization Practices (ACIP). • Preventive care for infants, children and adolescents (up to age 21) based on guidelines supported by HRSA, the American Academy of Pediatrics (AAP) and Bright Futures: – Child health supervision services including pediatric preventive services, routine immunizations, developmental assessments and appropriate laboratory services for children from birth to the end of month which they turn age 21 • Measurements (blood pressure, length, height, weight, BMI, head circumference) • Sensory screenings • Routine hearing assessments and/or exams for individuals 21 years and younger • Routine eye exams for individuals 21 years and younger. One examination is covered every calendar year.		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

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

• Developmental/behavioral health screenings
  • Developmental screening (9, 18 and 30 months)
  • Autism spectrum disorder screening (18 and 24 months)
  • Development surveillance
  • Psychosocial/behavioral assessment
  • Tobacco, alcohol and drug use assessment (beginning at age 11)
  • Depression screening (beginning at age 12)
  • Maternal depression screening (1, 2, 4 and 6 months)
• Procedures
  • Newborn blood screening
  • Newborn bilirubin screening
  • Critical congenital heart defect screening
  • Anemia screening
  • Lead screening
  • Tuberculosis screening
  • Dyslipidemia screening
  • Sexually transmitted infections screening
  • HIV screening
  • Cervical dysplasia screening
• Oral Health
  • Fluoride varnish
  • Fluoride supplementation		

Contact Customer Services or go to **ucare.org** to learn about specific preventive health services and services that are USPSTF rated A or B, and services included in guidelines supported by HRSA and Bright Futures recommendations. **Note: Non-preventive services (those not listed above) provided during your well visit will be covered as non-preventive/diagnostic (e.g., certain lab tests such as Thyroid Stimulating Hormone (TSH), Basic Metabolic Panel (BMP), and Complete Blood Count (CBC)). If you receive preventive and non-preventive (diagnostic) health services during the same visit, the non-preventive (diagnostic) health services may require you to pay a copayment, coinsurance or deductible. The most specific and appropriate benefit in the Benefits Chart will apply for each service received during a visit.**		
RECONSTRUCTIVE SURGERY DUE TO CANCER		
We cover reconstruction of the breast following a mastectomy, surgery and reconstruction of the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
RETAIL CLINIC/CONVENIENCE CARE CLINIC VISITS		
We cover retail clinic/convenience care clinic visits staffed by nurse practitioners or other eligible providers.	$10 copayment per visit (unlimited visits).	You pay 50% after the non-network deductible has been met.
SKILLED NURSING FACILITY SERVICES		
We cover room and board, daily skilled nursing and related services for post-acute treatment and rehabilitative care of illness or injury, following a hospital stay. Skilled nursing facility services are limited to 120 days per admission. Solely to assure adequate training of the hospital staff to communicate with a ventilator-dependent patient, we cover up to 120 hours of services from a private duty nurse or personal care assistant who has provided home care services to that patient. Authorization required. See the *Authorization and Notification* section in this Contract.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Services not covered include: • Private duty nursing services, except if the covered person is also covered under Medical Assistance • Services for items for personal convenience		

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
SUBSTANCE ABUSE DISORDER INPATIENT SERVICES		
We cover inpatient substance abuse services in a hospital and chemical dependency assessments performed by a licensed alcohol and drug counselor when medically necessary. We cover residential care for the treatment of substance abuse in a licensed facility, as an alternative to inpatient care, when it is medically necessary. We cover detoxification services in a hospital or community detoxification facility. Authorizations or notifications may be required for select services. See the *Authorization and Notification* section in this Contract.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

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

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
SUBSTANCE ABUSE DISORDER INTENSIVE OUTPATIENT SERVICES		
We cover chemical dependency outpatient services, including intensive outpatient and day treatment. We also cover the following services for a diagnosed chemical dependency condition: 1. Opiate replacement therapy including methadone and buprenorphine treatment 2. Day treatment in a licensed program If we or a participating provider determines that no structured treatment is necessary, you are entitled to a second opinion by a health care professional not affiliated with UCare who is qualified to diagnose and treat the condition. We will consider the second opinion, but are not obligated to accept the conclusion of the second opinion. There is no cost to you for this second opinion. Authorizations or notifications may be required for select services. See the *Authorization and Notification* section in this Contract.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
SUBSTANCE ABUSE DISORDER OFFICE VISITS		
We cover medically necessary substance abuse or chemical dependency assessment services by a licensed alcohol and drug counselor. We cover treatment of Substance-Related Disorders as defined in the latest edition of the DSM–5. We cover outpatient professional services for the diagnosis and treatment of chemical dependency. Chemical dependency treatment services must be provided by a program licensed by the state in which the servies are provided. Office visits for a diagnosed chemical dependency condition include individual, group, family and multi-family therapy provided in an office setting. If we or a participating provider determines that no structured treatment is necessary, you are entitled to a second opinion by a health care professional not affiliated with UCare who is qualified to diagnose and treat the condition. We will consider the second opinion, but are not obligated to accept the conclusion of the second opinion. There is no cost to you for this second opinion. Authorizations and notifications may be required for select services. See the *Authorization and Notification* section in this Contract.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). For subsequent visits, you pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Services not covered include: • Professional services associated with substance abuse intervention (e.g., a gathering of family and/or friends to encourage a person covered under this Contract to seek substance abuse treatment).		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
TRANSPLANT SERVICES		
We cover eligible transplant services while you are our member. Transplants considered for coverage are limited to: • Kidney transplants • Cornea transplants • Heart transplants • Lung transplants • Heart/lung transplants • Liver transplants • Bone marrow transplants • Pancreas transplants UCare requires hospitals and providers to notify us prior to administering transplant services. See the *Authorization and Notification* section in this Contract. Charges for transplant services must be incurred at a designated transplant center. This is any health care provider, group or association of health care providers designated by UCare to provide transplant services, supplies and drugs to our members. Transplant services are defined as transplantation (including retransplants) of the human organs or tissue listed above. This includes all related post-surgical treatment and drugs, and multiple transplants for a related cause. Transplant services do **not** include organs not listed above, tissue transplants or surgical implantation of mechanical devices that function as a human organ. An exception is the surgical implantation of FDA-approved Ventricular Assist Devices (VAD) functioning as a temporary bridge to heart transplantation.	You pay 25% after the in-network deductible has been met. If UCare determines that your transplant cannot be provided by an in-network provider, UCare will work with you and your care team to identify and designate an appropriate non-network provider for transplant services as described in this Contract. In-network benefits would apply for a non-network provider in this situation.	You pay 50% after the non-network deductible has been met. If UCare directs your care to a non-network provider, you pay 25% after the **in-network** deductible has been met (in-network cost-sharing levels apply).

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
Transplant-related treatments, including expenses incurred for directly related donor services, are subject to and in accordance with the provisions, limitations, maximums and other terms of this Contract. Medical and hospital expenses of the donor are covered only when the recipient is a member. Treatments of medical complications that may occur to the donor are not covered. Donors are not considered members, and are therefore not eligible for the rights afforded to members under this Contract.		
VISION		
We cover diagnosis and treatment of illness or injury to the eyes. When contacts or eyeglass lenses are prescribed as medically necessary for the post-operative treatment of cataracts, or for the treatment of aphakia or Keratoconous, we cover the initial evaluation, lenses and fitting. Members must pay for lens replacement beyond the initial pair. Note: For routine eye exams for members younger than the age of 19 see the *Preventive Care/Screening/ Immunization* section of the *Benefits Chart*.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). For subsequent visits, you pay 25% after the in-network deductible has been met. Eyewear and contact lenses: You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.
Vision services not covered: • Routine eye exams for adults • Keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, except as described in this Contract		

DESCRIPTION OF SERVICES	What you pay when using in-network providers	What you pay when using non-network providers*
VOLUNTARY FAMILY PLANNING		
We cover the following services from a non-network provider, at the same level of coverage as from an in-network provider: • The voluntary planning of conceiving and bearing children – Includes education and counseling • Testing and treatment of a sexually transmitted disease – Includes testing for AIDS and related conditions	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 25% after the in-network deductible has been met. Lab services and testing: You pay 25% after the in-network deductible has been met.	For each of the first three office visits in a plan year, you pay $40. First three visits can be any combination of eligible visits (see *Office Visits* for a list of eligible visits). After three visits you pay 25% after the **in-network** deductible has been met. Lab services and testing: You pay 25% after the **in-network** deductible has been met.
X-RAYS AND IMAGING		
We cover X-rays and imaging such as MRI, CT and PET scans, when medically necessary, ordered by a provider, and conducted in a clinic, outpatient or other medical facility.	You pay 25% after the in-network deductible has been met.	You pay 50% after the non-network deductible has been met.

*In addition to the non-network deductible and coinsurance, you will be responsible for any charges from the provider that exceed the amount UCare reimburses the provider.

Exclusions – Services Not Covered

In addition to any other benefit exclusions, limitations and terms specified in this Contract, we will not cover charges incurred for any of the following services, except as specifically described in this Contract:

- Treatment, procedures, services and drugs that are not medically necessary and/or that are primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the member. This includes cognitive retraining and skills training.
- Procedures, technologies, treatments, facilities, equipment, drugs and devices that are considered investigative, or otherwise not clinically accepted medical services
- Halfway houses, extended care facilities or comparable facilities, foster care, adult foster care, and family child care provided or arranged by the state or county
- Services associated with non-covered services, including but not limited to diagnostic tests, monitoring, laboratory services, drugs and supplies
- Elective abortion services in cases of normal pregnancy, except in cases when the life of the mother would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or when the pregnancy is the result of rape or incest
- Services from non-medically licensed facilities or providers, and services outside the scope of practice or license of the individual or facility providing the service
- Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise medically necessary. Examples are custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI), competency evaluations and adoption studies.
- Services and/or surgery for gender reassignment, except if medically necessary based on the most recent, published medical standards by nationally recognized medical experts in the transgender health field
- Routine foot care, except if medically necessary
- Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as required by Minnesota law. This exclusion does not apply to oral amino acid-based elemental formula if it meets our medical coverage criteria.
- Charges for sales tax
- Genetic counseling and genetic studies, except when the results would influence a treatment or management of a condition or family planning decision. Our medical policies (medical coverage criteria) are available by calling Customer Services, or going to **ucare.org**.
- Services provided by a family member of the enrollee, or a resident in the enrollee's home
- Services provided to a member who has other primary insurance coverage for those services and does not provide us with the necessary information to pursue Coordination of Benefits, as required under this Contract
- The portion of a billed charge of an otherwise covered service by a non-network provider that exceeds the allowed amount. We also do not cover charges or a portion of a charge that is either a duplicate charge for a service or charges for a duplicate service.
- Charges for services (i) which would not have been made in the absence of insurance or health plan coverage, or (ii) which the member is not obligated to pay, and (iii) from providers who waive copayment, deductible and coinsurance payments by the member, except in cases of undue financial hardship

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

Submitting a Claim

In-network providers typically file claims on your behalf for services you receive while under their care. If you receive a bill from an in-network provider for a covered service, you may submit the claim directly to UCare (see *How to Submit a Claim* below for details). UCare will pay in-network providers directly for covered services under this plan. You are responsible for any related cost-sharing.

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

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

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

How to Submit a Claim

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

Mail claims to:
UCare
Attention: Claims
P.O. Box 70
Minneapolis, MN 55440-0070

Call Customer Services at the number inside the front cover if you have questions about a bill you have received or want more information on how to submit a claim.

To help us efficiently process a claim, you should:

- Submit the claim within 12 months of receiving the service. Claims received 365 or more days after the date of service will be denied.
- Be prepared to provide additional details, such as copies of bills from the provider, proof of payment (if already paid), and other documents that may be needed to process the claim.

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

If your claim is denied in whole or in part, UCare will provide a specific reason in writing. If you disagree with our decision, you have the right to request an appeal. See the *Appeals and Complaints* section of this Contract for how to request an appeal.

You should keep copies of all itemized paid-in-full receipts and correspondence for your records.

Payment of Claims During the Grace Period

If you receive Advanced Premium Tax Credit (APTC) through MNsure, federal law requires UCare to provide a three-month grace period before terminating coverage. The grace period only applies if you receive APTC and have paid at least one full month's premium within the benefit year.

During the first month of the grace period, UCare is required to pay claims for covered services received during the first month. If you fail to pay the unpaid premium amount in full within the second or third month of the grace period, UCare will pend or hold those claims. If premiums are paid in full within the three-month grace period, previously pended or held claims will be processed according to covered benefits. If you fail to pay the unpaid premium amount in full before the end of the three-month grace period, your coverage will be terminated as of the last day of the first month and claims incurred for month two and month three will be denied. You are responsible for paying the full cost of services in months two and three of the grace period.

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

Coordination of Benefits (COB)

When COB Applies

1. Coordination of benefits (COB) applies to this plan when a member has health care coverage under more than one plan. *Plan* and *this plan* are defined below.

2. If you have other coverage in addition to this plan, your coverage under this plan is determined by the *Order of Benefit Determination Rules* (described below). Under the *Order of Benefit Determination Rules*, the benefits of this plan:

   a. Shall not be reduced when this plan determines its benefits before another plan; but

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

Definitions that Apply to COB

1. **Plan***:* Refers to any of the following that provides benefits or services for, or because of, medical or dental care/treatment:

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

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

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

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

2. **This plan**: The part of this Contract that provides benefits for health care expenses.

3. **Primary plan/secondary plan**: The *Order of Benefit Determination Rules* state whether this plan is a primary plan or secondary plan when a member has health care coverage under more than one plan.

   When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

   When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When there are two or more plans covering a member, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

4. **Allowable expense**: A necessary, reasonable and customary item of expense for health care, when the cost is covered at least in part by one or more plans covering the person for whom the claim is made.

   The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an allowable expense under this definition, unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in the plan.

   The difference between the charges billed by a provider and the non-network provider reimbursement amount is not considered an allowable expense under the above definition. See the *Provider Payment* section of this Contract for more information.

   When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense.

Examples are those related to surgical second opinions and in-network provider arrangements.

5. **Claim determination period**: Defined as one calendar year.

   However, it does not include any part of the year during which a person has no coverage under this plan, or any part of the year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

1. **General**. When there is a basis for a claim under this plan and another plan, this plan is a secondary plan that has its benefits determined after those of the other plan, unless:

   a. The other plan has rules coordinating its benefits with the rules of this plan; and

   b. Both the other plan's rules and this plan's rules, in section 2. immediately below, require that this plan's benefits be determined before those of the other plan.

2. **Rules**. This plan determines its order of benefits using the first of the following rules which applies:

   a. **Nondependent/dependent.** The benefits of the plan that covers the person as a member or enrollee (other than as a dependent) are determined before those of the plan that covers the person as a dependent.

   b. **Dependent child/parents not separated or divorced**. Except as stated in 2.c. below, when this plan and another plan cover the same child as a dependent of different persons, called *parents*:

      i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

      ii. If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

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

   c. **Dependent child/separated or divorced parents.**

   If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

      i. First, the plan of the parent with custody of the child;

      ii. Then, the plan of the spouse of the parent with the custody of the child; and

      iii. Finally, the plan of the parent not having custody of the child.

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

   d. **Joint custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plan(s) providing coverage will follow the *Order of Benefit Determination Rules* outlined in 2.c. above.

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

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

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

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

Effect on the Benefits of this Plan

1. **When this section applies.** This *Effect on the Benefits of this Plan* section applies when, in accordance with the *Order of Benefit Determination Rules* section above, this plan is considered a secondary plan to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as *the other plans* in section 2. immediately below.

2. **Reduction in this plan's benefits.** The benefits of this plan will be reduced when the sum of:

   a. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and

   b. The benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, UCare may pay that amount to the organization

that made the payment. That amount will then be treated as though it were a benefit paid under this plan.

UCare will not have to pay that amount again. The term *payment made* includes providing benefits in the form of services, in which case *payment made* means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by UCare is more than what should have been paid under this COB provision, UCare may recover the excess from one or more of the following:

1. The persons it has paid or for whom it has paid
2. Insurance companies or
3. Other organizations

The amount of the *payments made* includes the reasonable cash value of any benefits provided in the form of services. See the *Right of Recovery* section below for more information.

Right of Recovery

This section describes UCare's right of recovery, including rights to reimbursement and subrogation. Subrogation is when we pay a claim for an injury or illness that was caused by a third party, and then try to recover that amount from the third party. UCare's rights are subject to Minnesota and federal law. For information about the effect of Minnesota and federal law on UCare's subrogation rights, contact an attorney.

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

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

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

By accepting coverage under this Contract, you agree:

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

Appeals and Complaints

Coverage Decisions

At any time, you or your provider can contact Customer Services to inquire about your benefits, or request a coverage decision on what is covered under this plan and how much we will pay. If you disagree with this coverage decision, you can file an appeal.

To File an Appeal

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

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

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

If your oral or written appeal does not require a medical determination, we will notify you within 10 calendar days that we received your appeal. We will tell you our decision within 30 calendar days from our receipt of your appeal.

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

We will notify you within 10 calendar days that we received your appeal. We will tell you our decision within 30 calendar days from our receipt of your appeal. In addition:

- We will provide written notice of our appeal review decision to you and your provider, when applicable, within 30 calendar days from receipt of your appeal. For pre-service appeals only, we may take up to 14 additional days to make a medical determination due to circumstances beyond our control. If we take more than 30 days to make a decision, we will inform you and provide the reason for the extension. Post-service disputes will be resolved within 30 calendar days from receipt of your appeal.
- When an initial decision by UCare not to grant an authorization request is made before or during an ongoing service requiring our authorization, and your attending provider believes that UCare's decision warrants an expedited appeal, you or your attending provider will have the opportunity to request an expedited review by telephone.
- If our appeal review decision upholds our initial decision, you have the right to request an external review. You may also request an external review prior to our decision if we waive the internal review process, we fail to substantially comply with any of our review requirements including, but not limited to time limits, or you applied for an expedited external review at the same time you qualify for and applied for an expedited internal review as explained below.
- If our appeal review decision is partially or wholly adverse to you, we will inform you of your right to submit a complaint regarding our decision for an external review. We will include the details explaining how to begin the external review process.

Expedited Review

If your attending provider determines the need for an expedited review, you or your attending provider can request an expedited review by telephone. If we conclude that a delay could seriously jeopardize your

life, health or ability to regain maximum function, we will process your appeal as an expedited review. We will then notify you and your provider by telephone of our decision no later than 72 hours after receiving the request.

External Review of an Adverse Decision

If you are not satisfied with UCare's review decision, you may request an external review through the State of Minnesota. For decisions related to in-network services, contact the Minnesota Department of Health. For decisions regarding non-network services, contact the Minnesota Department of Commerce.

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

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

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

Independent Review of an Adverse Non-formulary Drug Coverage Decision

If UCare denies coverage for a non-formulary drug, you may request an external exception review by an independent review organization. UCare contracts with an independent review organization on behalf of our members.

For expedited independent review requests, we will notify you and your provider of the decision no later than 24 hours after receiving the request. For standard independent review requests, we will notify you and your provider of the decision no later than 72 hours after receiving the request. Please note, submitting a request for independent review does not prevent you from requesting a review using all other appeal rights described in the *Appeals and Complaints* section. You can use any appeal right at any given time during the appeal process.

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

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

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

Complaints

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

- Complaints must be made within 180 calendar days after the problem you are contacting us about.
- If you call us with a complaint, we will notify you within 10 calendar days of our decision. If we do not notify you within 10 calendar days, you may file a written complaint.
- For written complaints, we will notify you within 10 calendar days that we have received your written complaint. Within 30 days we will send you a written response of our findings or decisions. If we need more information or if you ask for more time, it may take up to 14 more calendar days to repsond to your complaint.

To issue a complaint, call Customer Services at one of the numbers inside the front cover. We will inform you of any additional action that may be needed. If

you call us with a complaint, we may be able to give you an answer during that phone call. If we need more information or time, we will tell you.

If you do not wish to call, or you called and were not satisfied, you can submit your complaint in writing. Call Customer Services if you need help submitting your complaint in writing.

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

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

You can deliver your written complaint to UCare offices at:

500 Stinson Boulevard NE
Minneapolis, MN 55413

You have the right to an external review by an independent entity. To request an external review form, contact:

Minnesota Department of Health
651-201-5100 or 1-800-657-3916 toll free
Email: health.mcs@state.mn.gov

You also have the right to file a complaint with the Minnesota Commissioner of Health or Commissioner of Commerce at any time during the complaint or appeals process. To contact the Minnesota Department of Commerce call 651-539-1600 or 1-800-657-3602 toll free.

Eligibility and Enrollment

Eligibility

This Contract covers individuals and dependents, as applicable, who have enrolled in coverage. Eligibility is determined by MNsure if you enrolled through MNsure. Eligibility is determined by UCare if you enrolled directly through UCare.

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

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

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

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

If you become eligible for and/or enroll in Medicare, we cannot use this as a basis for nonrenewal or termination. You may request to terminate coverage.

Service Area

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

Dependents

For purposes of this Contract, dependents eligible for coverage are individuals for whom the enrollee requests coverage including:

- Legally married spouse
- Dependent children up to age 26 including:
  - Natural-born children
  - Step-children
  - Legally adopted children
  - Children for whom you or your covered spouse have been appointed legal guardians
  - Dependent child of domestic partner of unmarried enrollee meeting domestic partnership requirements. See the *Definitions* section for information on requirements.
  - Other children including grandchildren who have lived with you continuously since birth and are financial dependents of you or your covered spouse; and children required to be covered by reason of a Qualified Medical Child Support Order.
- Disabled children who have reached age 26 while under this Contract if: the child is both (i) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability, and (ii) dependent upon the enrollee for support and maintenance.
- Domestic partners of unmarried enrollees. For purposes of this Contract, includes both same sex and opposite sex domestic partners. See the *Definitions* section for information on requirements.

Effective Date of Coverage

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

Changes in Coverage

You must enroll in coverage during the annual Open Enrollment period, unless you experience a qualifying event during the coverage period. Qualifying events permit eligible members or dependents to make changes to existing coverage or enroll during a special enrollment period. You must report the special enrollment triggering event and select a plan during the special enrollment period. The notice must be reported within 60 days of the triggering event, except as noted below:

- Gain or become a dependent due to marriage
- Gain a dependent due to birth, adoption, placement for adoption, foster care or child support order. This event can be reported after the 60-day period, but the premium must be paid to effectuate coverage if you select coverage back to the date of birth, adoption, placement for adoption, foster care or child support order.
- Loss of dependent(s) due to death, divorce or legal separation
- Gain citizenship, national or lawfully present status
- Loss of existing Minimum Essential Coverage. This includes losing employer-based coverage, losing coverage due to divorce or family changes, COBRA coverage ends, age off parent's plan by turning 26 years old, and losing eligibility for Medicaid or other government sponsored coverage. It does not include voluntary terminations or loss of coverage due to not paying premiums.
- Change in circumstances that cause a change to or new eligibility for Advanced Premium Tax Credit or Cost Sharing Reduction
- Enrollment or non-enrollment was unintentional, inadvertent or erroneous and due to error, misrepresentation or inaction by MNsure or U.S. Department of Health and Human Services.
- Current Qualified Health Plan issuer substantially violates material provision of the Contract

Other special enrollment triggering events may be available through mnsure.org. Please contact mnsure.org for more information, including when coverage would begin and what is needed to verify a triggering event.

Renewing Coverage

During the annual open enrollment period, you can either continue with the current plan or change coverage for the upcoming year. Annual open enrollment is the period identified each year during which you and your dependents may enroll in coverage.

Premiums

UCare offers several easy ways to pay your monthly premium. You must pay your premium in full by the 20th of the month prior to the coverage month.

Your payment options are:

- Automatic withdrawal from a checking/savings account: complete and return the automatic payment form on **ucare.org**. Automatic withdrawal will occur between the 20th and 23rd of the month prior to coverage.
- Online bill pay/Direct pay from your bank: This option is completed through your bank. Contact your bank to learn more. Make sure your payment is addressed to UCare, PO Box 856532, Minnespolis, MN 55485-6532.
- Pay online using a VISA or MasterCard debit or credit card: Log in to your secure member account on **ucare.org** and follow the instructions.
- Check or money order mailed to: UCare, PO Box 856532, Minneapolis, MN 55485-6532.

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

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

Grace Period

Information on the grace period for paying premiums is in the *Ending Coverage* section. If you pay the premiums in full at any time during the grace period, this Contract will remain in force. If premium is not paid in full by the end of the grace period, coverage will end as stated in the *Ending Coverage* section.

Ending Coverage

When Coverage Ends

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

1. You request termination in writing and provide notice that you have obtained other minimum essential coverage. In this event, the last day of coverage under this Contract will be:

    a. The last day of the month, specified by you, if you provide at least 14 days notice;

    b. Fourteen days after the termination is requested, if the notice above is not supplied;

    c. On a date determined by UCare, if we are able to end coverage in fewer than 14 days and you request an earlier termination date; or

    d. The last day before your Medicaid, Children's Health Insurance Program (CHIP), or Basic Health Program (BHP) coverage begins, if you are newly eligible for any of these programs.

2. You choose another plan during the annual open enrollment period or any special enrollment period. The last date of coverage shall be the last date of the month prior to your new coverage becoming effective.

3. You are no longer eligible for coverage, (example: you move out of the State of Minnesota or outside the geographic service area for this Contract). The last day of coverage in this case shall be the last day of the month following the month in which the notice is sent to you, unless you request an earlier termination date.

4. You fail to pay monthly premiums for coverage on time and the grace period has run out.

    For individuals receiving Advanced Premium Tax Credits (APTC) who have paid at least one full month's premium, the federal government has established a three-month grace period. Failure to pay premiums in full during the grace period will result in termination from the plan. The last day of coverage in this event shall be the last day of the first month of the three-month grace period. See *Payment of Claims During the Grace Period* to understand the potential financial impact of termination for non-payment.

    For individuals who do not receive APTC subsidies, the grace period is 31 days from their premium due date, or as otherwise required by Minnesota law. Coverage shall end on the last day of the last month for which premium payment was received by UCare. See *Payment of Claims During the Grace Period* to understand the potential financial impact of termination for non-payment.

    At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will be responsible for any unpaid premiums in the prior 12 months from your prior enrollment with UCare.

5. You terminate this Contract within the first 10 days of receiving it. Coverage shall terminate retroactive to the effective Contract date.

6. You perform an act, practice or omission that constitutes fraud, or make an intentional misrepresentation of a material fact with respect to this Contract. Fraud includes but is not limited to:

    a. Knowingly providing UCare with false material information;

    b. Permitting the use of member identification card by any unauthorized person;

    c. Using another person's member identification card;

    d. Submitting fraudulent claims; and

    e. Engaging in fraudulent activity related to eligibility for coverage under this Contract.

    In this event, coverage ends on the date specified by UCare in written notice to you that coverage ended due to fraud or intentional misrepresentation of a material fact. Coverage may be retroactively terminated at UCare's

discretion to the original date of coverage or the date on which the fraudulent act took place. UCare will provide you with at least 30 days advance written notice of any decision under this section.

7. The last day of the month when UCare notifies you that UCare will cease doing business or will discontinue a particular product under Minnesota law. This includes refusal to renew all of UCare's existing individual health plans and cancellation of all outstanding individual health plan contracts.

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

Harmful Use of Services

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

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

If you fail to use those identified providers for non-emergency services, it may result in a denial of coverage. If you require care or services from a provider other than your coordinating health care providers, we may require a referral from your coordinating health care provider.

There is no restriction for emergency care.

General Contract Provisions

Entire Contract and Changes to this Contract

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

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

Acceptance of Coverage in this Contract

By your acceptance of the health services coverage described in this Contract, you authorize use of a Social Security number for identification purposes, and you agree that the information you provided in the application and as part of the enrollment process is accurate and complete. You understand and agree that any incorrect or incomplete statements made as part of application and enrollment under this Contract may make this Contract invalid as allowed by applicable law.

Clerical Error

A clerical error will neither deprive you of coverage nor create a right to benefits not covered under this Contract. However, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination.

Access to Records and Confidentiality

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

Relationship Between Parties

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

Assignment

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

Notice

Except as otherwise stated in this Contract, written notice given by UCare will be considered notice to all affected in administering this Contract in the event of termination or nonrenewal of this Contract. However, notice of termination for nonpayment of premium shall be given by UCare to the member.

Discretionary Authority

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

Misstatement Time Limit

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

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

Definitions

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

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

Allowed Amount: The maximum amount on which payment is based for covered services. This may also be called "eligible expense," "payment allowance," or "negotiated rate." If your non-network provider charges more than the allowed amount, you may have to pay the difference. (See the *Balance Billing* and *Provider Payment* sections.)

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

Approved Clinical Trial: An approved phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology. To be considered an approved clinical trial, it must be: (i) conducted under an investigational new drug application reviewed by the United States Food and Drug Administration; (ii) exempt from obtaining an investigational new drug application; or (iii) approved or funded by certain governmental entities and their partners, or nongovernmental entities operating under governmental entity guidelines. If you have questions about whether a clinical trial is an approved clinical trial, call Customer Services.

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

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

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

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

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

Coinsurance: Your share of the costs of a covered health care service. Coinsurance is calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance **plus** any deductibles you owe. For example, if the plan's allowed amount for an office visit is $100 and you have met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount. In-network coinsurance usually costs you less than non-network coinsurance.

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

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

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

Copayment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the item or service. The amount can vary by the type of covered health care service. In-network copayments usually are less than non-network copayments. Copayments do not apply to your deductible. They do apply to your out-of-pocket limit.

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

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

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

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

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

Dependent: See Eligible Dependent.

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

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

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

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

– Are not married to anyone and are each other's sole domestic partner with the intent to remain together indefinitely
– Are each 18 years of age or older
– Are not related by blood closer than permitted under the state marriage laws where you reside
– Are each mentally competent to consent to a contract; and
– Have completed a domestic partnership affidavit form and agreed to the conditions of that form

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

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

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

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

Emergency Transportation: Ambulance services for an emergency medical condition.

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

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

Facility: A licensed medical center, clinic, hospital, skilled nursing care facility or outpatient care facility, lawfully providing a medical service in accordance with applicable governmental licensing privileges and limitations.

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

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

Grievance: A complaint that you make to your plan.

Habilitation Care: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

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

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

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

In-Network Provider: Network providers are physicians, other health care professionals, medical groups, hospitals, other facilities and pharmacies that have a contract with UCare to deliver health care services. See *Using the Network* for more information.

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

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

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

Medicaid/Medical Assistance: A joint federal-state health insurance program that is run by the states and covers certain low-income people (especially children and pregnant women), and people who are disabled.

Medical Necessity or Medically Necessary: Health service that is consistent with the member's diagnosis or condition and: (i) is recognized as the prevailing standard or current practice by the provider's peer group; and (ii) is delivered in response to a life threatening condition or pain; to treat an injury, illness or infection; to treat a condition that could result in physical or mental disability; to care for the mother and child through the maternity period; to achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition; or is a preventive health service.

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

Mental/Behavioral Health Professional: A psychiatrist, psychologist or mental health therapist licensed to provide mental health or chemical dependency services to our members, as covered in this Contract.

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

Network Provider: See *In-Network Provider.*

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

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

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

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

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

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

Physician: A licensed medical doctor or doctor of osteopathy, lawfully performing a medical service, in accordance with governmental licensing privileges and limitations, who renders medical or surgical care to our members as covered in this Contract.

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

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

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

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

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

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

Provider: Any licensed physician or non-physician (excluding naturopathic providers), lawfully performing a medical service in accordance with applicable governmental licensing privileges and limitations, who provides direct patient care to members as covered in this Contract.

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

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

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

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

Routine Patient Costs: All items and services consistent with the coverage provided in the plan (or coverage) that are typically covered for a member who is not enrolled in a clinical trial. Routine patient costs do not include (i) investigational items, devices or services being studied in an approved clinical trial; (ii) items and services provided solely to satisfy a clinical trial's data collection and analysis needs and that are not used in the direct clinical management of the patient; and (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a diagnosis.

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

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are considered to be those provided by health care technicians and therapists in your home or in a nursing home.

Skilled Nursing Facility: A licensed skilled nursing facility, lawfully performing medical services in accordance with governmental licensing privileges and limitations, and is recognized by us as an appropriate facility, to render inpatient post-acute hospital and rehabilitative care and services to our members. This does not include facilities that primarily provide treatment of mental or chemical health.

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

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

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