



2019

Summary of Benefits
EssentiaCare Comparison Guide

EssentiaCare
Essentia Health + UCare

Why EssentiaCare?

Medicare can feel overwhelming when you're trying to figure it out on your own. EssentiaCare can help.

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

UCare and Essentia Health have formed a special partnership to offer EssentiaCare, a network-based Medicare Advantage plan in Minnesota and northern Wisconsin.

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

access to Essentia Health

Doctors
& advance practitioners



Mayo
Clinic
in Rochester

your shopping checklist

3 easy steps

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

EssentiaCare Medicare Plans

Get all your health benefits in one plan



travel coverage



prescription drug
coverage



vision benefits



fitness options



dental coverage

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the ABC & D of Medicare

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

Understanding the four parts of Medicare

Original Medicare is made up of 2 parts – **Part A** and **Part B**



Part A – hospital coverage

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



Part B – medical coverage

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



**Additional coverage
and services**
*vision, hearing, dental,
health & wellness*

Medicare
Advantage Plan

Part C – Medicare Advantage Plan

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

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

Since 1997, people have had the option of getting their Medicare Part A and Part B benefits plus additional coverage all in one package through Medicare Advantage plans.



Part D – outpatient prescription drug coverage

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

You must choose whether or not to enroll in Part D when you first become eligible for

Medicare. Keep in mind that if you decline it, but decide you want this coverage later, you may have to pay a penalty.

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

When am I eligible for Original Medicare?

You qualify for Medicare if you:

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

How do I enroll in Original Medicare?

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

When can I enroll in a Medicare Advantage Plan?

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

Initial Coverage Election Period (ICEP)

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

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

Enroll when first eligible

You have a seven-month period (three months before, the month of, and three months after you become eligible).

**Example
birthday is July 4**



3 months before

3 months after

Late enrollment penalties

If you don't sign up for Part B and Part D when you first become eligible for Medicare, you may pay a penalty if you decide to sign up later. The penalty is added to your monthly premium, and you'll pay it for as long as you have Part B or Part D coverage. Some exceptions apply.

When can I make changes to my Medicare plan coverage?

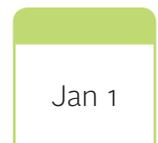
Annual Election Period (AEP)

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

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



**Annual Election
Period**



**Coverage
begins**

Special Enrollment Periods (SEPs)

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

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

Medicare Advantage Open Enrollment Period (MA-OEP)

During the MA-OEP, Medicare Advantage members may enroll in another Medicare Advantage plan or disenroll from their Medicare Advantage Plan and return to Original Medicare (limited to one change). Individuals may add or drop Part D coverage during this period. Specific time frames apply.

Now that you know the basics of Medicare, let's focus on
how to shop for a plan



Understand my costs

What do I want to pay?

Does it fit my budget?

- Copay - a set fee you pay for doctor/clinic visits or prescriptions
- Deductible - the initial amount you pay for health care services
- Coinsurance - the percentage of costs you pay for covered services
- Monthly premium - the amount you pay each month for coverage

Understand my health care needs

What I should consider?

- I want to keep the doctors I know and trust
- I'm healthy and only get yearly check-ups
- I want extras, like fitness benefits and dental coverage
- I want my plan to include prescription drug coverage

Understand which plan is best for me

Whatever your health care needs, budget or lifestyle, EssentiaCare has a plan for you. Get all the right benefits at the right price.



How to choose the right plan

Picture yourself in one of our plans

Secure

John is in good shape and doesn't foresee any large expenditures for health care. He wants a plan that gives him all-around coverage in case an old injury flares up, which is why EssentiaCare Secure is a great fit. It provides all-in-one coverage that includes Part D at a lower premium.

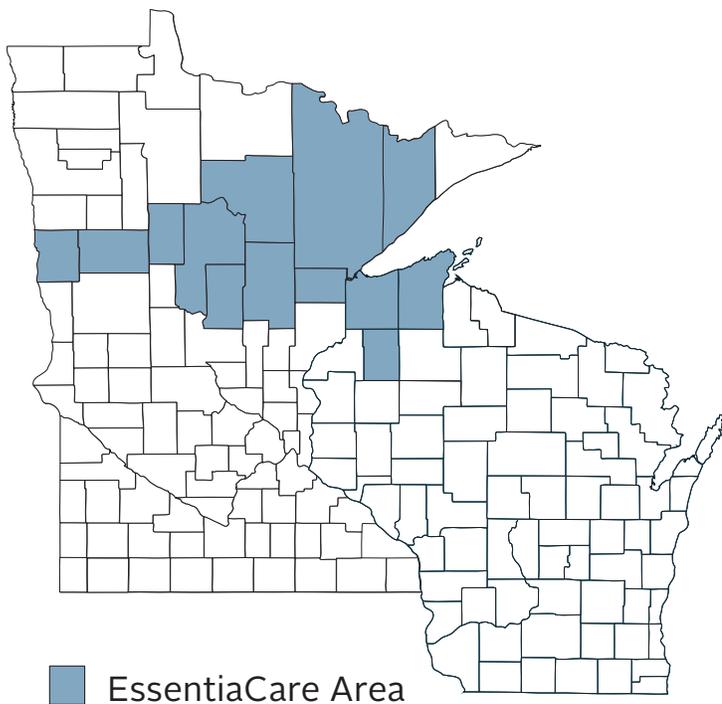
Grand

Gary has chronic heart issues and relies on the expertise of his care providers at Essentia Health to monitor and treat his condition. But he also wants the reassurance of knowing he's covered for more specialized care, should he need it. EssentiaCare Grand gives him peace of mind.



You're off to a great start. Now let's make sure EssentiaCare covers the

Is my plan offered where I live?



Medicare Plan Options

Secure (PPO)*

Grand (PPO)*

Minnesota Counties

Aitkin, Becker, Carlton, Cass, Clay, Crow Wing, Hubbard, Itasca, Lake and St. Louis

Wisconsin Counties

Bayfield, Douglas and Washburn

† For more information about plans available in other counties, please call a licensed Medicare Sales Specialist at 1-855-432-7027, TTY 1-800-688-2534, 8 am – 8 pm daily.

* PPO - Preferred Provider Organization.

I found a plan that fits my lifestyle. What's next?

area, providers and prescription drugs you need.

pay less
when you get care
from Essentia Health
providers

Is my doctor in the network? Are my prescription drugs covered?

Go to **ucare.org/medicare123**
your 1-stop shop to get you on your way



Find a doc

Search for a full list of EssentiaCare providers (including specialists, hospitals, dentists and chiropractors)

If you prefer, request a Provider and Pharmacy Directory at 1-855-432-7027.



Find a drug

Search our list of covered drugs.

If you prefer, use the printed 2019 Formulary provided. Check the alphabetical index in the back of the formulary, to find your drugs.

Time to compare the benefits and costs.

Choose the plan that fits your lifestyle

plan benefit details

Compare benefit, premium and coverage details among our EssentiaCare Medicare plans.

HEALTH CARE SERVICES	SECURE	GRAND
2019 monthly premium (you must continue to pay your Medicare Part B premium)	\$44	\$129
Medical deductible (out-of-network only)	In-network \$0 Out-of-network \$1,000	In-network \$0 Out-of-network \$500
Part D deductible	Tier 1 = \$0 Tiers 2-5 = \$400	Tiers 1-2 = \$0 Tiers 3-5 = \$250
Out-of-pocket maximum A limit on how much you have to pay out-of-pocket for in-network Medicare-covered services each year. Excludes Medicare Part D and all other non-Medicare covered services and premium.	In-network \$4,500 Out-of-network combined with in-network: \$10,000 Once you have paid this amount, you are covered at 100% for benefits for the remainder of the calendar year	In-network \$3,500 Out-of-network combined with in-network: \$7,000 Once you have paid this amount, you are covered at 100% for benefits for the remainder of the calendar year
Hospital Care		
Inpatient hospital care (per admission)	\$300 copay per day (days 1-5); then 100% covered	\$500 copay per stay, then covered 100%
Outpatient hospital or procedure	\$300 copay	\$250 copay
Doctor visits		
• Primary	\$0 copay	\$0 copay
• Specialist	\$45 copay	\$35 copay
Preventive care		
Routine physical exam	\$0 copay	\$0 copay
Routine eye exam and hearing test	\$0 copay	\$0 copay
“Welcome to Medicare” preventive visit (if in the first 12 months on Part B)	\$0 copay	\$0 copay
Annual Wellness Exam (if you had Part B for more than 12 months)	\$0 copay	\$0 copay

HEALTH CARE SERVICES	SECURE	GRAND
Immunizations – Flu and pneumonia vaccines. (Shingles vaccine is covered under Medicare Part D.)	\$0 copay	\$0 copay
Mammogram screening	\$0 copay	\$0 copay
Pap smears and pelvic exams	\$0 copay	\$0 copay
Prostate cancer screening exam	\$0 copay	\$0 copay
Bone mass measurement	\$0 copay	\$0 copay
Diabetes screening	\$0 copay	\$0 copay
Preventive colorectal cancer screening	\$0 copay	\$0 copay
Cardiovascular screening	\$0 copay	\$0 copay
Resources to stop using tobacco	\$0 copay	\$0 copay
Emergency/Urgent care at home and while traveling in the United States		
Emergency care – Copay is waived if admitted to the hospital within 24 hours for the same condition; then inpatient hospital copay would apply.	In-network \$90 copay Out-of-network \$90 copay	In-network \$90 copay Out-of-network \$90 copay
Urgently needed services – Medically necessary and immediately required as a result of an unforeseen illness, injury or condition.	In-network \$45 copay Out-of-network \$45 copay	In-network \$45 copay Out-of-network \$45 copay
Worldwide emergency care		
Applies to care outside the United States and U.S. territories.*	\$90 copay	\$90 copay

In general, out-of-network cost-sharing in the U.S. applies deductible, then coinsurance (Secure 25%, Grand 20%); cost-sharing is the same both in and out-of-network for some services. This does not apply to dental services. See the section on optional dental coverage for more information about out-of-network dental services.

Note: Your hospital status, meaning whether the hospital considers you an “inpatient” or “outpatient,” affects how much you pay for hospital services. Inpatient hospital care copays apply if you are admitted to the hospital with a doctor’s order.

HEALTH CARE SERVICES	SECURE	GRAND
Miscellaneous Services		
Diagnostic tests (e.g., MRI and CT scans), radiation therapy and X-rays	10% coinsurance up to a maximum of \$75 per day	10% coinsurance up to a maximum of \$50 per day
Lab services (e.g., Protime INR, cholesterol)	\$0 copay	\$0 copay
Hearing services	\$45 copay	\$35 copay
Preventive Dental Services included in your plan (no additional premium)		
One oral examination per calendar year	One paid in full	One paid in full
One cleaning per calendar year	One routine paid in full	One routine paid in full
Bitewing X-rays every 12 months	\$0 copay	\$0 copay
Topical application of fluoride in conjunction with a routine cleaning or examination.	Paid in full	Paid in full
Optional dental (For an additional premium you can access more covered services. See page 24 for details.)		
Optional comprehensive dental	<i>Choice Dental</i>	<i>Choice Dental</i>
Vision Services		
Routine eye exam You are covered for one routine eye exam and up to two refractions every year	\$0 copay	\$0 copay
Exam to diagnose and treat diseases and conditions of the eye (\$0 copay for yearly glaucoma screening)	\$45 copay	\$35 copay
Diabetic retinopathy exam	\$0 copay	\$0 copay
Eyeglasses or contact lenses after cataract surgery	\$0 copay	\$0 copay
Annual allowance for eyeglasses or contacts at any provider	None	None

HEALTH CARE SERVICES	SECURE	GRAND
Mental Health Services		
Inpatient hospital stay (90 days limit per stay) • Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general hospital.	\$300 copay per day (days 1-5); then 100% covered	\$500 copay per stay; then 100% covered
Outpatient mental health care	\$40 copay	\$35 copay
Skilled Nursing Facility Care (or swing bed)^		
Covered services include but are not limited to: Semiprivate room and necessary skilled medical services at network facilities; private rooms are covered if medically necessary; including physical therapy, occupational therapy and speech-language pathology	\$0 copay per day for days 1-20; \$150 copay per day for days 21-100; per benefit period No prior hospitalization is required*	\$0 copay per day for days 1-20; \$125 copay per day for days 21-100; per benefit period No prior hospitalization is required*
Other Services		
Physical therapy	\$40 copay	\$35 copay
Ambulance • Includes air and/or ground if transport and level of service are medically necessary and meet Medicare guidelines.	In-network \$300 copay Out-of-network \$300 copay	In-network \$150 copay Out-of-network \$150 copay
Transportation	Not covered	Not covered

***No prior hospitalization is required** – With both of our EssentiaCare options, we waive the three-day Medicare-covered hospital stay that is required by Medicare and many of our competitors. This means you may have access to coverage in more situations.

In general, out-of-network cost-sharing in the U.S. applies deductible, then coinsurance (Secure 25%, Grand 20%); cost-sharing is the same both in and out-of-network for some services. This does not apply to dental services. See the section on optional dental coverage for more information about out-of-network dental services.

^ Service requires pre-authorization.

Choose the plan that fits your lifestyle

prescription drug coverage

HEALTH CARE SERVICES	SECURE	GRAND
Medicare Part B Drugs[^]		
Generally, drugs that must be administered by a health professional.	20% coinsurance	20% coinsurance
Medicare Part D Coverage included with these plan options (no additional premium)		
Annual Deductible Stage – You pay the full cost of your drugs until you reach this amount.	\$0 for Tier 1 \$400 for Tiers 2-5	\$0 for Tiers 1 & 2 \$250 for Tiers 3-5
Initial Coverage Stage – From \$0 to \$3,820 in annual prescription drug costs. After you meet the deductible you pay the amounts listed below.		
Cost Sharing - Retail: Our network includes preferred pharmacies, which offer lower cost sharing than standard network pharmacies..		
Tier 1 Preferred generic drugs	Retail - 30 day supply Preferred: \$1 copay Standard: \$8 copay	Retail - 30 day supply Preferred: \$1 copay Standard: \$8 copay
Tier 2 Generic drugs	Retail - 30 day supply Preferred: \$10 copay Standard: \$17 copay	Retail - 30 day supply Preferred: \$7 copay Standard: \$14 copay
Tier 3 Preferred brand drugs	Retail - 30 day supply Preferred: \$40 copay Standard: \$47 copay	Retail - 30 day supply Preferred: \$35 copay Standard: \$42 copay
Tier 4 Non-preferred drugs	Retail - 30 day supply Preferred: 45% coinsurance Standard: 50% coinsurance	Retail - 30 day supply Preferred: 45% coinsurance Standard: 50% coinsurance
Tier 5 Specialty drugs	Retail - 30 day supply Preferred: 25% coinsurance Standard: 25% coinsurance	Retail - 30 day supply Preferred: 28% coinsurance Standard: 28% coinsurance

Cost-sharing may differ based on point-of-service (mail-order, retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our preferred or standard network, or whether the prescription is a short-term (30-day supply) or long-term (90-day supply).

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

[^] Service requires pre-authorization.

HEALTH CARE SERVICES	SECURE	GRAND
Coverage Gap Stage		
<p>Once you have reached \$3,820 in annual prescription drug spending (your cost plus UCare's cost), you pay as shown.</p> <p>You stay in this stage until your out-of-pocket costs reach \$5,100.</p> <p><i>Notes: Your coverage gap is \$5,100 minus the portion of the \$3,820 that you paid out of your own pocket.</i></p> <p><i>The size of the coverage gap is NOT \$5,100 minus \$3,820.</i></p>	<p>37% of the cost of generic drugs.</p> <p>25% of the cost of brand-name drugs</p>	<p>37% of the cost of generic drugs.</p> <p>25% of the cost of brand-name drugs</p>
Catastrophic Coverage Stage		
<p>Once you have reached \$5,100 in annual "out-of-pocket" costs, you pay as shown.</p>	<p>You pay The greater of \$3.40 or 5% coinsurance for generic drugs.</p> <p>The greater of \$8.50 or 5% coinsurance for all other drugs.</p>	<p>You pay The greater of \$3.40 or 5% coinsurance for generic drugs.</p> <p>The greater of \$8.50 or 5% coinsurance for all other drugs.</p>

Extra Help for Part D

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

To see if you qualify, call:

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

Some people will pay a higher premium for Part D coverage because their yearly income is over certain amounts (over \$85,000 for singles, over \$170,000 for married couples).

What are my prescription drug options?

You'll need to fill your prescriptions at pharmacies in your plan network, except in special cases. Network pharmacies include mail order, preferred and standard pharmacies.

Mail order through Express Scripts

- **Safe** – 99.99% accuracy
- **Convenient** – Free standard shipping, flexible payment options and automatic refills with three ways to order:
 - mail
 - call
 - online
- **Savings** – 90-day supply of maintenance medications for two copays

Learn more about Express Scripts in your new member packet.

Preferred Pharmacies

- **Value** – Pay less for your medications when you use a preferred network pharmacy.
- **Choice** – Choose from more than 23,000 pharmacies, including CVS/Target, Costco, Cub Foods, Sam's Club/Walmart and Essentia Health pharmacies.

Standard Pharmacies

- **More Choices** – Choose from more than 60,000 local and nationwide chain pharmacies
- **Flexibility** – Most retail pharmacies will fill 90-day prescriptions



To find a preferred pharmacy, use the online search tool at ucare.org/medicare123

If you prefer, request a Provider and Pharmacy Directory at 1-855-432-7027

Choose the plan that fits your lifestyle

additional benefits

HEALTH CARE SERVICES	SECURE	GRAND
Additional Benefits		
Chiropractic services[^] <ul style="list-style-type: none"> Covers visits for manual manipulation of the spine to correct subluxation Must use a ChiroCare network provider 	\$20 copay	\$15 copay
Home health agency care[^] Skilled medical services by a Medicare-certified home health care agency when you are home bound	\$0 copay	\$0 copay
Hospice If you enroll in a Medicare-certified hospice program, hospice services and services covered by Medicare Part A, and are related to your terminal condition, will be covered by Medicare (rather than our plan). Your hospice provider will bill Medicare directly.	Covered by Medicare	Covered by Medicare
Podiatry services <ul style="list-style-type: none"> Treatment of injuries and diseases of the feet Routine foot care for members with certain medical conditions affecting the lower limbs 	\$45 copay	\$35 copay

In general, out-of-network cost-sharing in the U.S. applies deductible, then coinsurance (Secure 25%, Grand 20%); cost-sharing is the same both in and out-of-network for some services.

[^] Service requires pre-authorization

HEALTH CARE SERVICES	SECURE	GRAND
Supplies		
Hearing aids	Not covered	Not covered
Durable medical equipment (e.g., oxygen equipment, CPAP) [^]	20% coinsurance	20% coinsurance
Diabetic <ul style="list-style-type: none"> • Continuous blood glucose monitors • Other glucose monitors • Test strips, and lancets <i>(Insulin and syringes covered under Medicare Part D)</i>	20% coinsurance 20% coinsurance 20% coinsurance	20% coinsurance \$0 copay \$0 copay
Prosthetic devices (e.g., braces, colostomy bags and supplies)	20% coinsurance	20% coinsurance
Fitness Programs		
EssentiaCare offers two different fitness options to choose from to stay active and feel great! The fitness program you select (option 1 or option 2) is included with both EssentiaCare Medicare plans.		
Option 1: SilverSneakers® Program To see a list of participating locations, go to silversneakers.com	Free basic membership at over 14,000 locations nationwide	Free basic membership at over 14,000 locations nationwide
Option 2: Health Club Savings Program (at a participating health club not in the SilverSneakers network) To see a list of participating clubs, go to ucare.org/healthwellness	Up to \$20 per month	Up to \$20 per month

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[^] Service requires pre-authorization

What about fitness and health club benefits?

SilverSneakers® Fitness Program

Whether you're close to home or traveling, you can use your SilverSneakers membership however, and whenever it works for you. This fitness program includes:

- A free basic fitness membership at more than 14,000 locations in the SilverSneakers network
- Online support
- SilverSneakers FLEX™ fitness classes
- At-home fitness kit options for stress relief, strength, walking, and yoga

How it works

To find clubs and classes where you live or travel, visit silversneakers.com or call 1-888-423-4632, Monday – Friday from 7 am – 7 pm CST.



Health Club Savings

Join a class, work with weights, swim some laps, or try something new. Health Club Savings offers the variety you want and the flexibility you deserve. If you belong to a participating health club that is not in the SilverSneakers network, you can receive a reimbursement of up to \$20 in your monthly health club membership fees.

How it works

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



brighten your smile with

optional dental coverage

Choice Dental is available with both EssentiaCare Secure and Grand. You can enroll in this extra dental coverage when you first enroll in your health plan by checking the box on your enrollment form. You are still eligible to enroll during your first covered month, and after that, annually during the Annual Election Period (10/15 – 12/7) for coverage beginning January 1 (forms cannot be accepted before October 15). A separate enrollment form is required if you do not enroll when you first join our health plan.

You can find in-network providers using the online search tool at ucare.org, or you can call 1-855-432-7027 (TTY 1-800-688-2534) for assistance, 8 am – 8 pm, seven days a week.

	CHOICE DENTAL
Premium	\$21 per month
Deductible	\$75 per year (not applicable for some services)
Annual maximum	\$1,000 per covered person, per coverage year.*

*This annual maximum is in addition to the preventive dental coverage provided in your EssentiaCare Secure and Grand plans. You will get the best benefit by using a network dentist. EssentiaCare uses the Delta Dental Medicare Advantage Network administered by Delta Dental of Minnesota.

Unlike most other dental plans, you may also use an out-of-network licensed dentist (who has not opted out or been excluded from Medicare) within the United States and its territories. Services rendered by dentists who have opted out or been excluded from Medicare are not eligible for reimbursement. If you receive dental services from a non-network licensed provider, you may be responsible for submitting your bills and paying the cost share and any difference between the dentist's fees and the allowable amount. To request out-of-network reimbursement, submit the payment receipt obtained from your dentist to Delta Dental, P.O. Box 330, Mpls., MN 55440-0330.

Limitations

Endodontics: Limited to one (1) per tooth per lifetime.

Periodontics: Coverage is limited to one (1) non-surgical periodontal treatment and one (1) surgical periodontal treatment per quadrant every 36 months.

Oral/Maxillofacial Surgery: Coverage is limited to once per site (upper/lower ridge) in conjunction with building the bony ridge needed for successful placement of an implant or removable prosthetics (partial/full dentures).

Major Restorative Services: Benefit for the replacement of a crown or an onlay will be provided only after a five (5) year period, measured from the last date the covered dental service was performed.

	CHOICE DENTAL
Additional preventive oral exam per calendar year	One (no deductible applies)
Additional routine cleaning of the teeth per calendar year	One (no deductible applies)
Full mouth X-rays every 5 years	One set (no deductible applies)
Basic Services <ul style="list-style-type: none"> • Silver or resin fillings • Emergency treatment for relief of pain (minor procedures) • General anesthesia or I.V. sedation 	30% coinsurance
Endodontics <ul style="list-style-type: none"> • Root canal therapy on permanent teeth, including pulpotomies • Indirect pulp-cap • Root canal retreatment (mutually exclusive of final restoration) 	30% coinsurance
Periodontics <ul style="list-style-type: none"> • Periodontal maintenance cleanings (deep cleaning of the gums) • Full-mouth debridement • Non-surgical periodontics: Procedures necessary for the treatment of diseases of the gingival (gums) • Surgical periodontics: The surgical procedures necessary for the treatment of the gingival (gums) and bone supporting the teeth 	\$0 copay 30% coinsurance
Oral/Maxillofacial Surgery <ul style="list-style-type: none"> • Surgical and non-surgical extractions for tooth removal, including pre- and post-operative care. • Bone grafting as part of surgical procedure. 	30% coinsurance

Prosthetics – removable and fixed: A prosthetic appliance (denture or bridge) for the purpose of replacing an existing appliance will be covered only after five (5) years.

Implant Services: Replacing a single missing anterior (front) tooth. Coverage for implants is limited to one per lifetime per tooth (also see Exclusion #19).

Exclusions of Services

While some of the exclusions shown below may be covered services under the terms of the Evidence of Coverage (EOC), the following are not covered dental services under the dental rider:

1. Services rendered by dentists who have opted out or been excluded from Medicare are not eligible for reimbursement.

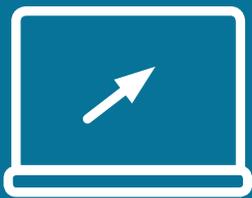
2. Dental services that are not necessary or specifically covered.
3. Hospitalization or other facility charges.
4. Prescription drugs.
5. Any dental procedure performed solely as a cosmetic procedure.
6. Charges for dental procedures completed prior to the member's effective date of coverage.
7. Anesthesiologist services.
8. Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings.

<p>Major Restorative Services</p> <ul style="list-style-type: none"> • Emergency services – major procedures. • Special restorative procedures to restore lost tooth structure as a result of tooth decay or fracture. • Crowns, when the amount of lost tooth structure does not enable the placement of a filling material. • Cast onlays for treatment of severe carious lesions and severe fractures when the tooth cannot be restored with amalgam, porcelain, or plastic crown. 	60% coinsurance
<p>Prosthetics</p> <ul style="list-style-type: none"> • Repairs and adjustments on removable and fixed bridges, standard partial dentures, and full dentures for the replacement of fully extracted permanent teeth. 	60% coinsurance
<p>Implant services</p> <ul style="list-style-type: none"> • Surgical placement of an implant body to replace single missing natural anterior (front) tooth. • Porcelain or ceramic crown over implant body. 	60% coinsurance

9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles, except as provided under Oral Surgery in the EOC.
10. Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions.
11. Oral hygiene instruction and periodontal exam.
12. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture.
13. Any oral surgery that includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery in the EOC.
14. Analgesia (nitrous oxide).
15. Removable unilateral dentures.
16. Temporary procedures.
17. Splinting.
18. Consultations by the treating provider and office visits.
19. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's effective date. Exception: This exclusion will not apply for any member who has been continuously covered under the comprehensive dental benefit package for more than 24 months.
20. Occlusal analysis, occlusal guards (night guards) and occlusal adjustments (limited and complete).
21. Veneers (bonding of coverings to the teeth).
22. Orthodontic treatment procedures.
23. Corrections to congenital conditions, other than for congenital missing teeth.
24. Athletic mouth guards.
25. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment, except as noted in the EOC.
26. Space maintainers.

- enrolled in Original Medicare
- selected the plan that fits my lifestyle
- enroll in a EssentiaCare Medicare Advantage plan

3 ways to enroll



online

[ucare.org/
medicare123](https://ucare.org/medicare123)

fast and easy

secure data transfer

save enrollment to
finish at later time



by mail

fill out the 4-page
enrollment form and
mail in the postage-paid
envelope



call

call 1-855-432-7027
to enroll with a
licensed Medicare
Sales Specialist

or call to find a trusted
UCare broker near you

Enrollment

Choose a clinic

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

Forms by mail

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

Once we receive your enrollment application, you:

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

Should you require medical services or prescription drugs before you receive your ID card, please call Customer Services at 877-523-1515 (TTY 800-688-2534).

How to pay your premiums

You can choose to pay your premium either by: **Automatic Payment/Electronic Funds Transfer (EFT), Mail or Social Security or Railroad Retirement Board Withdrawal.** You cannot charge your premium to a credit card. Please do not send money with your enrollment form.

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-855-432-7027.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit ucare.org or call 1-855-432-7027 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

Additional information

Provider network coverage

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

Learn about special services

Care Management

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

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

Prior Authorizations

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

The Benefits Chart section of the Evidence of Coverage includes this information for each of our EssentiaCare Medicare Plans. This information is also at [ucare.org](https://www.ucare.org).

Consider Medicare coverage limits

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

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Private room in a hospital, except when it is considered medically necessary or if it is the only option available.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care — care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged for care by your immediate relatives or members of your household.
- Cosmetic surgery or procedures, unless covered in case of an accidental injury or for improvement of the functioning of a malformed body member. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine chiropractic care, other than manual manipulation of the spine to correct a subluxation.
- Home-delivered meals.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).

- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids or exams to fit hearing aids.
- Eyeglasses radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
- Reversal of sterilization procedures, and/or non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).

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

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: 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>.

Notice of Privacy Practices

Effective Date: July 1, 2013

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

Questions?

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

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

Why are we telling you this?

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

What do we mean by “information?”

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

What kinds of information do we use?

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

What do we do with this information?

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

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

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

In addition, we may use your information to provide you with appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We may also share information with family members or others you identify as involved with your care, or with the sponsor of a group health plan, as applicable.

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

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

Who sees your information?

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

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

and Human Services to investigate our compliance efforts. There may be other situations when the law requires or permits us to share information.

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

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

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

What are your rights?

- You have the right to ask that we don't use or share your information in a certain way. *Please note that while we will try to honor your request, we are not required to agree to your request.*
- You have the right to ask us to send information to you at an address you choose or to request that we communicate with you in a certain way. For example, you may request that your mailings be sent to a work address rather than your home address. We may ask that you make your request in writing.
- You have the right to look at or get a copy of certain information we have about you. This information includes records we use to make decisions about health coverage, such as payment, enrollment, case, or medical management records. We may ask you to make your request in writing. We may also ask you to provide information we need to answer your request. We have the right to charge a reasonable fee for the cost of making and mailing the copies. In some cases, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will tell you in writing. We may give you a right to have the decision reviewed. Please let us know if you have any questions about this.
- You have the right to ask us to correct or add missing information about you that we have in our records. Your request needs to be in writing. In some cases, we may deny a request if the information is correct and complete, if we did not

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

- You have the right to receive a listing of the times when we have shared your information in some cases. Please note that we are not required to provide you with a listing of information shared prior to April 14, 2003; information shared or used for treatment, payment, and health care operations purposes; information shared with you or someone else as a result of your permission; information that is shared as a result of an allowed use or disclosure; or information shared for national security or intelligence purposes. All requests for this list must be in writing. We will need you to provide us specific information so we can answer your request. If you request this list more than once in a 12-month period, we may charge you a reasonable fee. If you have questions about this, please contact us at the address provided at the end of this Notice.
- You have the right to receive notifications of breaches of your unsecured protected health information.
- You have the right to receive a copy of this Notice from us upon request. This Notice took effect July 1, 2013.

How do we protect your information?

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

What else do you need to know?

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

Choose the plan that fits your lifestyle

	SECURE	GRAND
Premium	\$44	\$129
Medical, Hospital	✓	✓
Fitness Programs	✓	✓
Preventive Dental	✓	✓
Option for Comprehensive Dental	✓	✓
Part D prescription drug coverage	✓	✓
Travel	✓	✓

Compare benefit highlights

For services at in-network providers

HEALTH CARE SERVICES	SECURE	GRAND
2019 monthly premium	\$44	\$129
Preventive care	\$0 copay for many services	\$0 copay for many services
Doctor visits (no referrals needed)	Primary: \$0 copay Specialist: \$45 copay	Primary: \$0 copay Specialist: \$35 copay
Inpatient hospital care (per admission)	\$300 copay per day (days 1-5); then 100% covered	\$500 copay per stay; then 100% covered
Diagnostic tests, x-rays	10% coinsurance up to a maximum of \$75 per day	10% coinsurance up to a maximum of \$50 per day
Lab services	\$0 copay	\$0 copay
Emergency care worldwide	\$90 copay	\$90 copay
Urgent care	\$45 copay	\$45 copay
Ambulance	In-network \$300 copay Out-of-network \$300 copay	In-network \$150 copay Out-of-network \$150 copay
Medicare Part D prescription drug coverage	Annual deductible: Tier 1 = \$0; Tiers 2-5 = \$400 Copays based on drug tiers, as low as \$1	Annual deductible: Tiers 1-2 = \$0; Tiers 3-5 = \$250 Copays based on drug tiers, as low as \$1
Dental coverage	Includes preventive dental additional <i>Choice Dental</i> available for \$21 per month	Includes preventive dental. Additional <i>Choice Dental</i> available for \$21 per month.
Vision and hearing coverage	\$0 copay for annual routine eye exam and hearing test \$0 copay for glaucoma screening \$0 copay for diabetic retinopathy exam \$45 copay for diagnostic eye and hearing exams	\$0 copay for annual routine eye exam and hearing test \$0 copay for glaucoma screening \$0 copay for diabetic retinopathy exam \$35 copay for diagnostic eye and hearing exams
SilverSneakers® fitness	Free basic membership at 14,000 locations nationwide	Free basic membership at 14,000 locations nationwide
Out-of-pocket maximum	\$4,500	\$3,500
Travel	Worldwide emergency care and out-of-network benefit coverage	Worldwide emergency care and out-of-network benefit coverage

EssentiaCare

Essentia Health + UCare

UCare

4310 Menard Drive, Suite 600
Hermantown, MN 55811

500 Stinson Blvd
Minneapolis MN 55413

218-722-4783 | 1-855-432-7027 | TTY 1-800-688-2534

8 am – 8 pm, 7 days a week

ucare.org

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