

A guide to comparing your options . . .



UCare for Seniors Value (HMO-POS)
UCare for Seniors Standard D (HMO-POS)
UCare for Seniors Value Plus (HMO-POS)
UCare for Seniors Classic (HMO-POS)

Minnesota

2012

Health care that starts with you.SM

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Contact information

While we tried to cover everything in this booklet, we realize that you may have additional questions. Please do not hesitate to give us a call at the numbers listed below, visit our web site, or come to one of our offices.

UCare's Sales Department – available 8 a.m. to 8 p.m., daily.	612-676-3500 1-877-523-1518 toll free
UCare's Customer Services Department – available 24 hours, daily.	612-676-3600 1-877-523-1515 toll free
If you are hearing impaired, please use UCare's Sales and Customer Services TTY machine line.	TTY 612-676-6810 TTY 1-800-688-2534 toll free
Medicare – available 24 hours per day, 7 days per week.	1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)
Online – click on “ <i>Check out our Medicare Options.</i> ”	www.ucare.org
UCare's Minnesota office	500 Stinson Blvd. NE, Minneapolis, MN 55413
UCare's Wisconsin office	3410 Oakwood Mall Rd., Suite 500, Eau Claire, WI 54701

This document is available in alternative formats (e.g., large print). Please call the numbers above for more information.

About us

UCare is an independent, nonprofit health plan providing health coverage and services to more than 230,000 members in Minnesota and western Wisconsin.

Since its founding in 1984 by the Department of Family Practice and Community Health at the University of Minnesota, UCare has grown to become a leading health plan.

Working in partnership with health care providers and community organizations, UCare serves:

- Medicare-eligible individuals.
- Families and individuals enrolled in Minnesota Health Care Programs, such as MinnesotaCare and Medical Assistance.
- Adults with disabilities.

Are you eligible?

To be eligible for *UCare for Seniors*, you must:

- Have Medicare Part A and Part B (by age or disability). You must continue to pay your Medicare Part B premium (if not otherwise paid for under Medicaid or by another third party).
- Reside in the service area (the state of Minnesota and 26 counties in western Wisconsin*).
- Not have end-stage renal disease (kidney failure), in most cases.

No physical exam or other health screening is required. You must enroll within a valid election period. (See page 26 for information on election periods.)

Why join *UCare for Seniors*?

With *UCare for Seniors*, you get the coverage you need along with:

- **Freedom of choice.** With four levels of coverage, you can choose the option that fits your needs and your budget.
- **Simplicity.** UCare contracts with the federal government to administer both Medicare Part A and Part B, and UCare provides additional benefits - all in one coordinated package. Three of our plan options include Part D (outpatient prescription drug coverage). Once you join, there is virtually no paperwork.
- **Access.** Our provider network includes more than 7,019 physicians, 16,526 specialists, and 230 hospitals. Even when you travel, you maintain excellent coverage.
- **Satisfaction.** We work hard to keep our members satisfied. In 2010, the Medicare Program issued *UCare for Seniors* a rating of 4.5 out of 5 stars for quality and performance.[†] In 2009, our members rated UCare's Medicare Advantage plan as a 8.79 out of 10 for Overall Rating of Health Plan. This score is higher than the national and state average.

**For more information about our Wisconsin service area, please call the UCare for Seniors Sales Department at the number on page 2.*

†Centers for Medicare & Medicaid Services, Medicare Health Plan Ratings

UCare for Seniors basic overview

	Value	Standard D	Value Plus	Classic
2012 monthly premium	\$43	\$54	\$84	\$137
Primary care doctor office visits	\$0 co-pay	\$0 co-pay	\$0 co-pay	\$0 co-pay
Specialist office visits	\$30 co-pay	\$35 co-pay	\$30 co-pay	\$15 co-pay
Inpatient hospital care	100% after \$300 co-pay per inpatient admission	100% after \$500 co-pay per inpatient admission	100% after \$300 co-pay per inpatient admission	100% after \$150 co-pay per inpatient admission
Worldwide emergency care - Co-pay is waived if admitted to the hospital within 24 hours for the same condition.	\$65 co-pay	\$65 co-pay	\$65 co-pay	\$65 co-pay
Medicare Part D prescription drug coverage	Not covered	<ul style="list-style-type: none"> • \$320 annual deductible • Closed formulary 	<ul style="list-style-type: none"> • No deductible • Open formulary 	<ul style="list-style-type: none"> • No deductible • Open formulary • More coverage for generics in gap
Dental coverage	Not covered	Not covered	Not covered	Preventive dental paid in full. Additional <i>UCare Comprehensive Dental</i> coverage available for \$21/month .

UCare for Seniors basic overview (continued)

	Value	Standard D	Value Plus	Classic
Vision coverage	<p>\$0 co-pay for annual routine eye exam</p> <p>\$30 co-pay for diagnostic eye exam</p>	<p>\$0 co-pay for annual routine eye exam</p> <p>\$35 co-pay for diagnostic eye exam</p>	<p>\$0 co-pay for annual routine eye exam</p> <p>\$30 co-pay for diagnostic eye exam</p>	<p>\$0 co-pay for annual routine eye exam</p> <p>\$15 co-pay for diagnostic eye exam</p> <p>\$75 annual plan benefit maximum for eyeglasses or contacts at any provider</p>
Hearing aid benefit	Not covered	Not covered	Not covered	\$500 plan benefit maximum every 36 months

See a more detailed benefit comparison starting on page 10.

Please note: You cannot be a member of the Value plan and a stand-alone Medicare Part D prescription drug plan at the same time. If you want both medical coverage and prescription drug coverage, choose the Standard D, Value Plus, or Classic plans. If you enroll in the Value plan and already have a stand-alone Part D plan, you will be disenrolled from the stand-alone plan and will not have Part D coverage. If you have the Value plan and enroll in a Part D plan, you will be disenrolled from the Value plan.

Frequently asked questions

When and how do I enroll in Medicare?

Even though the retirement age for full Social Security benefits is increasing, you will still get Medicare at age 65 (if qualified).

If you are receiving Social Security benefits prior to age 65, you should automatically receive your Medicare card approximately three months before your 65th birthday. Your Medicare Part A and Part B will start on the first of the month of your birthday (unless your birthday falls on the first, then it will start the first of the previous month).

If you are not drawing Social Security benefits prior to age 65, you will need to contact Social Security (not Medicare) at 1-800-772-1213 (TTY 1-800-325-0778) to enroll in Medicare. (*Note: For Railroad retirees, the Railroad Retirement Board handles this enrollment at*

1-800-833-4455. TTY users call 312-751-4701.) Sign up early to avoid a delay in getting coverage for Part B. To get Part B coverage the month you turn 65, you must sign up during the three months before the month you turn 65. If you wait until the last four months of your Initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed.

When eligible for Medicare, if you have coverage through you or your spouse's (or partner's) active employer group plan, you may waive Part B in order to avoid paying the Part B monthly premium. Active means you (or your spouse or partner) are currently working. If the employer has 20 or fewer employees, check with the employer regarding how their coverage would interact with Medicare. When employment ends or you leave the employer group coverage (whichever occurs first), you

can apply for Part B to start on the first of the following month after termination using a Special Enrollment Period for Part B. You can then enroll in *UCare for Seniors* and request coverage to begin on the first of that month as well, so there is no break in coverage. If not done prior, once employment or group coverage ends, you have up to eight months to apply for Part B. If you apply for Part B within this timeframe, no Part B penalty will apply. If you choose to stay on a COBRA plan, please note that you must enroll in Part B within this eight month period or you will have to wait until the General Enrollment Period to apply for Part B (apply between 1/1 – 3/31 for 7/1 effective) and a penalty may apply.

Please note: Timeframes and penalties are different for Medicare Part D.

How is *UCare for Seniors* different from a Medicare supplement?

With a Medicare supplement, the bill you receive from your provider is first sent to Medicare to pay according to their schedule of coverage, then your supplement pays after that.

In contrast, *UCare for Seniors* is a Medicare Advantage plan that contracts with the federal government to administer Medicare Part A and Part B and the additional benefits included with *UCare for Seniors*. Having your health coverage in one coordinated package means you do not have to deal with Medicare's co-pays and deductibles, only the co-pays with our plan. Aside from filling out your initial enrollment form, there is virtually no paperwork. At a minimum, *UCare for Seniors* includes all the benefits provided by Original Medicare, plus more.

Because your *UCare for Seniors* membership covers your Medicare benefits, you will no longer use your Medicare card (even though you still have Medicare coverage). You will be issued a *UCare* member identification card that gives you access to the services and benefits provided.

Is my doctor in your network? Can I change my clinic at any time?

UCare for Seniors has a large provider network. When you enroll in *UCare for Seniors*, you choose a primary care clinic. (For a complete listing of primary care clinics, refer to the Provider section of the *UCare for Seniors* Provider and Pharmacy Directory.) Your primary care clinic is where you will go to receive most of your care. Within that clinic, you may see any physician. You

may change your primary care clinic at any time, for any reason, by logging into your member account at www.ucare.org or by calling *UCare's* Customer Services Department at the number on page 2. The change would become effective the first of the following month after we receive your request. **In addition, you may see any specialist in the *UCare for Seniors* network on your own, without a referral.**

You must use network providers for routine care, except for emergency care, out-of-area renal dialysis, urgent care, and Point-of-Service benefits (see page 15). With the exception of emergencies or urgent care, it may cost more to get care from out-of-network providers.

Do I have coverage when I am traveling?

Yes, *UCare for Seniors* provides comprehensive coverage for our members who travel outside the service area. This includes:

- Unlimited, worldwide emergency and urgently needed care coverage.
- Ambulance services within the United States.
- Out-of-area renal dialysis.
- Out-of-network, non-urgent, or non-emergency coverage called Point-of-Service at Medicare providers within the United States. You do not need a referral.

The Point-of-Service benefit may not be used for chiropractic services, transplants, dental services, and/or outpatient prescription drugs.

When traveling, you can be out of the service area for up to six consecutive months. If you are out of the service area for longer than this or make a permanent move outside the service area, Medicare requires that you disenroll from *UCare for Seniors*.

What is Medicare Part D? Do I have to take it?

Medicare Part D is a voluntary program that helps cover outpatient prescription drug costs. However, if you do not take it when first eligible for Medicare Part A or Part B, you may have to pay a penalty and wait until the next Annual Election Period to apply. The Part D penalty is calculated as 1% of the current national base beneficiary premium for each full, uncovered month that you were eligible to enroll in a Part D plan but did not. The national base beneficiary premium for Year 2012 is \$31.08. This penalty is applied monthly and continues for as long as you have Part D.

There are some situations when the penalty would not be applied, including, but not limited to: (1) If you qualify for Extra Help for Medicare Part D; (2) If you have maintained creditable drug coverage (at least as good as Medicare's). Examples of creditable coverage include drug coverage through the Veterans Administration and prescription drug coverage offered by many (but not all) employer group plans.

If you do not take Medicare Part D when first eligible because you are on a group employer plan, you will have a Special Election Period to enroll in Part D when your group plan ends and during the two months after your coverage ends.

What does Medicare Part D cost?

The cost of the Medicare Part D prescription drug coverage is built into the monthly premiums of the *UCare for Seniors* Standard D plan for \$54, Value Plus plan for \$84, and Classic plan for \$137. When you enroll in one of these plans, you are automatically enrolled in Part D. There is no separate premium to pay and no separate enrollment form to complete.

What is the specific Part D coverage with each *UCare for Seniors* plan?

Value

UCare for Seniors Value does not include Part D. Please note, you cannot be a member of the Value plan and a stand-alone Medicare Part D plan at the same time. If you want both medical coverage and prescription drug coverage, choose one of the options that follows.

Standard D

UCare for Seniors Standard D includes standard drug coverage. It has a "closed" formulary. This means it covers most generics but only some brand-name drugs. Drugs not listed in the formulary are not covered. There **is** an annual deductible with this plan option.

Deductible

You must pay a **\$320** annual deductible on covered Part D drugs before coverage begins.

Initial Coverage

There is a **25%** coinsurance until you have reached **\$2,930** in annual prescription drug costs (your cost plus *UCare's* cost).

Coverage Gap

Once you have reached **\$2,930** in annual prescription drug costs, you will receive a **50%** discount on brand-name drugs from manufacturers that have agreed with the Federal government to pay the discount (if not already receiving "Extra Help"). We will automatically apply the discount when your pharmacy bills you for your prescription, and you will receive an Explanation of Benefits that will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap. For generic drugs, you will pay **86%** of the cost of the drug. You continue to pay until your "out-of-pocket" costs reach **\$4,700**.

Catastrophic Coverage

Once **\$4,700** in annual out-of-pocket prescription drug costs has been reached, you pay the greater of:

- A **\$2.60** co-pay or **5%** coinsurance for generic drugs.
- A **\$6.50** co-pay or **5%** coinsurance for all other drugs.

UCare for Seniors will cover the rest.

Value Plus

UCare for Seniors Value Plus includes enhanced drug coverage. It has an "open" formulary. This means it covers all drugs (except for the excluded Part D classes, e.g., over-the-counter drugs). There **is no** deductible with this plan option.

Initial Coverage

Your co-pays for the first **\$2,930** of your annual prescription drug costs (your cost plus *UCare's* cost) are as follows:

- Up to a **\$10** co-pay per generic drug up to a 30-day supply (Tier 1).
- **\$35** co-pay per preferred brand-name drug up to a 30-day supply (Tier 2).
- **\$70** co-pay per other brand-name drug up to a 30-day supply (Tier 3).
- **25%** coinsurance per specialty drug (Tier 4).
- **Two co-pays** for a 90-day supply of maintenance drugs through our mail order program and at network retail pharmacies that offer a 90-day supply.

Coverage Gap

Once you have reached **\$2,930** in annual prescription drug costs, you will receive a **50%** discount on brand-name drugs from manufacturers that have agreed with the Federal government to pay the discount (if not already receiving “Extra Help”). We will automatically apply the discount when your pharmacy bills you for your prescription, and you will receive an Explanation of Benefits that will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap. For generic drugs, you will pay **86%** of the cost of the drug. You continue to pay until your “out-of-pocket” costs reach **\$4,700**.

Catastrophic Coverage

Once **\$4,700** in annual out-of-pocket prescription drug costs has been reached, you pay the greater of:

- A **\$2.60** co-pay or **5%** coinsurance for generic drugs.
- A **\$6.50** co-pay or **5%** coinsurance for all other drugs.

UCare for Seniors will cover the rest.

Classic

UCare for Seniors Classic plan includes enhanced drug coverage. It also has an “open” formulary. This means it covers all drugs (except for the excluded Part D classes, e.g., over the counter drugs). It also provides coverage for Tier 1 generic drugs throughout the coverage gap with a maximum co-pay of **\$10**. There **is no** deductible with this plan option.

Initial Coverage

Your co-pays for the first **\$2,930** of your annual prescription drug costs (your cost plus *UCare*’s cost) are as follows:

- Up to a **\$10** co-pay per generic drug up to a 30-day supply (Tier 1).
- **\$35** co-pay per preferred brand-name drug up to a 30-day supply (Tier 2).
- **\$70** co-pay per other brand-name drug up to a 30-day supply (Tier 3).
- **25%** coinsurance per specialty drug (Tier 4).
- **Two co-pays** for a 90-day supply of maintenance drugs through our mail order program and at network retail pharmacies that offer a 90-day supply.

Coverage Gap

Once you have reached **\$2,930** in annual prescription drug costs, you continue to have coverage for generic drugs throughout the coverage gap with the following co-pay or coinsurance:

- Up to a **\$10** co-pay per Tier 1 generic drug up to a 30-day supply.
- **86%** of the cost of any Tier 4 generic drug.
- **Two co-pays** for a 90-day supply of Tier 1 generic maintenance drugs through our mail order program and at network retail pharmacies that offer a 90-day supply.

During this time, you will receive a **50%** discount on brand-name drugs from manufacturers that have agreed with the Federal government to pay the discount (if not already receiving “Extra Help”). We will automatically apply the discount when your pharmacy bills you for your prescription, and you will receive an Explanation of Benefits that will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap. You continue to pay until your “out-of-pocket” costs reach **\$4,700**.

Catastrophic Coverage

Once **\$4,700** in annual out-of-pocket prescription drug costs has been reached, you pay the greater of:

- A **\$2.60** co-pay or **5%** coinsurance for generic drugs.
- A **\$6.50** co-pay or **5%** coinsurance for all other drugs.

UCare for Seniors will cover the rest.

How do I know if my drugs will be covered?

Since the coverage provided in these three plans is different, it is important to ensure that your prescriptions are covered. The Standard D plan has a “closed” formulary (list of covered drugs), meaning that it covers most generics but only some brand name drugs. The Value Plus and Classic plans have an “open” formulary, meaning that all drugs are covered (except for the excluded Part D classes). Please refer to the *UCare for Seniors* formulary for each plan to determine what drugs are covered and the specific tiers/co-pay levels.

How do I use the formulary?

Look up the name of each prescription drug in the alphabetical index at the back of the formulary, and refer to the page number listed. Next to each drug name are two columns. One column shows what tier the drug is in with the Value Plus and Classic plans, and the other shows what tier the drug is in with the Standard D plan.

In the Value Plus and Classic column:

For the first **\$2,930** of your annual prescription drug costs:

- A number “1” indicates that the drug is a generic drug with a co-pay of up to **\$10** per 30-day supply (Tier 1).
- A number “2” indicates that the drug is a preferred brand-name drug with a co-pay of up to **\$35** per 30-day supply (Tier 2).
- A number “3” indicates that the drug is an other brand-name drug with a co-pay of up to **\$70** per 30-day supply (Tier 3).
- A number “4” indicates that the drug is a specialty drug with a 25% coinsurance (Tier 4).

In the Standard D column:

For the first **\$2,930** of your annual prescription drug costs:

- A number “1” indicates that the drug is a covered generic with a coinsurance of 25% after the \$320 deductible is met (Tier 1).
- A number “2” indicates that the drug is a covered brand-name drug with a coinsurance of 25% after the \$320 deductible is met (Tier 2).
- The letters “NF” indicates that the drug is “non-formulary,” meaning it is not covered.

Where can I buy my prescriptions?

Members must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances.

You may get your drugs from a retail network pharmacy (see Pharmacy section of *UCare for Seniors* Provider and Pharmacy Directory). The network includes many local and nationwide chain pharmacies. The pharmacies that note “Offers a 90-day supply” will charge only two co-pays for a 90-day supply of maintenance drugs. Maintenance drugs are drugs that you take on a regular basis for chronic or long-term medical conditions. These drugs are denoted with an asterisk symbol (*) in the formulary.

You also have the opportunity to get your drugs by mail order from Express Scripts. You can use the mail order service to fill prescriptions for maintenance drugs and, for a 90-day supply, only two co-pays will be charged. After you enroll, more details will be provided in your new member packet.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/ 7 days a week.
- Social Security Administration at 1-800-772-1213. TTY users call 1-800-325-0778. Open 7 a.m. to 7 p.m., Monday – Friday.
- Your State Medicaid Office or County Human Services Office.
- Senior Linkage Line® at 1-800-333-2433.

Monthly plan premiums and benefits comparison

The chart starting on page 11 will help you understand the many benefits that *UCare for Seniors* provides. Use the chart to compare *UCare for Seniors* to your present health coverage. In the end, you will discover that *UCare for Seniors* truly offers tremendous value for your health care dollar.

Monthly Plan Premiums

<i>UCare for Seniors</i>			
Value	Standard D	Value Plus	Classic
\$43/month	\$54/month	\$84/month	\$137/month

Some people will pay a higher premium for Part D coverage because of their yearly income (over \$85,000 for singles; over \$170,000 for married couples). UCare Minnesota and UCare Wisconsin, Inc. are health plans with Medicare contracts.

Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1, 2013.

Limitations, co-payments, and restrictions may apply. The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For full information on our benefits, call the UCare for Seniors Sales Department at the number on page 2.

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Preventive Health Care

• Routine physical exam (one per calendar year)	Paid in full	Paid in full	Paid in full	Paid in full
• Immunizations - Flu and pneumonia vaccines - Hepatitis B vaccine (for people at risk*)	Paid in full	Paid in full	Paid in full	Paid in full
• Mammogram screening (for women age 40 and older (one per calendar year), and one baseline mammogram between the ages of 35-39)	Paid in full	Paid in full	Paid in full	Paid in full
• Pap smears and pelvic exams (one each per calendar year)	Paid in full	Paid in full	Paid in full	Paid in full
• Prostate cancer screening exam for men age 50 and older (one per calendar year)	Paid in full	Paid in full	Paid in full	Paid in full
• Bone mass measurement (for people at risk*)	Paid in full	Paid in full	Paid in full	Paid in full
• Screening colonoscopy (for people at risk* – every 24 months)	Paid in full	Paid in full	Paid in full	Paid in full
• Cardiovascular screening (every 5 years) – blood test to detect conditions that may lead to heart attack or stroke (tests cholesterol, lipid, and triglyceride levels)	Paid in full	Paid in full	Paid in full	Paid in full
• Diabetes screening (for people at risk*)	Paid in full	Paid in full	Paid in full	Paid in full
• HIV screening lab tests (for people at risk*)	Paid in full	Paid in full	Paid in full	Paid in full

*The reference “for people at risk” may mean persons with a positive family history of the condition, obesity, previous personal history, or other abnormalities as determined by their physician.

Note: Per Medicare guidelines, the shingles vaccine (Zostavax) and tetanus/diphtheria shot are covered under Medicare Part D.

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Outpatient Care

<ul style="list-style-type: none"> • Doctor office visits (with your primary care physician) 	Paid in full	Paid in full	Paid in full	Paid in full
<ul style="list-style-type: none"> • Specialist office visits (e.g., cardiologist) <ul style="list-style-type: none"> – Includes second opinion by another network provider prior to surgery. 	\$30 co-pay	\$35 co-pay	\$30 co-pay	\$15 co-pay
<ul style="list-style-type: none"> • Diagnostic tests, X-rays, and lab services <ul style="list-style-type: none"> – With all plan options no co-pay is charged for lab services (including blood work) received at a primary care or specialist clinic in our network. 	\$25 co-pay per procedure type	\$35 co-pay per procedure type	\$25 co-pay per procedure type	Paid in full
<ul style="list-style-type: none"> • Outpatient surgery (includes services provided at ambulatory surgical centers - e.g., cataract surgery) 	\$200 co-pay	\$250 co-pay	\$200 co-pay	\$100 co-pay
<ul style="list-style-type: none"> • Diagnostic colonoscopies* 	\$200 co-pay	\$250 co-pay	\$200 co-pay	\$100 co-pay

*Note: If during a screening colonoscopy a biopsy is needed, it is still considered a screening colonoscopy and no co-pay is charged.

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Medicare Part B Drugs

- The drugs covered under Medicare Part B are generally drugs that must be administered by a health professional. Some of these include antigens, certain oral anti-cancer drugs and anti-nausea drugs, injectable osteoporosis drugs (if homebound and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug), clotting factors you give yourself by injection if you have hemophilia, and drugs you take using durable medical equipment (such as nebulizers) that are authorized by a *UCare for Seniors* provider.

Note: See pages 7-8 for details on how the shingles vaccine and tetanus/diphtheria shot are covered under Medicare Part D.

Members pay a \$50 co-pay, or the cost of the drug(s) if less, per office visit for Part B drugs infused or administered in a physician's office or outpatient setting. Members pay a \$25 co-pay per generic drug or \$50 co-pay per brand-name drug at a retail pharmacy, or the cost of the drug if less.

Members pay a \$50 co-pay, or the cost of the drug(s) if less, per office visit for Part B drugs infused or administered in a physician's office or outpatient setting. Members pay a \$25 co-pay per generic drug or \$50 co-pay per brand-name drug at a retail pharmacy, or the cost of the drug if less.

Members pay a \$50 co-pay, or the cost of the drug(s) if less, per office visit for Part B drugs infused or administered in a physician's office or outpatient setting. Members pay a \$25 co-pay per generic drug or \$50 co-pay per brand-name drug at a retail pharmacy, or the cost of the drug if less.

Members pay a \$50 co-pay, or the cost of the drug(s) if less, per office visit for Part B drugs infused or administered in a physician's office or outpatient setting. Members pay a \$25 co-pay per generic drug or \$50 co-pay per brand-name drug at a retail pharmacy, or the cost of the drug if less.

Inpatient Hospital Care

- Semi-private room, meals, special diets (private rooms are covered if medically necessary or if semi-private rooms are not available)
- Inpatient physician and surgical services
- Operating room, special care units
- Drugs furnished while in the hospital
- Laboratory tests
- X-ray tests and other radiology services

100% after a \$300 co-pay per inpatient admission

100% after a \$500 co-pay per inpatient admission

100% after a \$300 co-pay per inpatient admission

100% after a \$150 co-pay per inpatient admission

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Other Supplies and Services

<ul style="list-style-type: none"> Physical therapy, occupational therapy, and/or speech-language pathology 	\$30 co-pay per visit	\$35 co-pay per visit	\$30 co-pay per visit	\$15 co-pay per visit
<ul style="list-style-type: none"> Durable medical equipment (e.g., oxygen equipment, wheelchairs, nebulizers, hospital beds, CPAP) 	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
<ul style="list-style-type: none"> Prosthetic devices (e.g., braces, artificial limbs and eyes, colostomy bags and supplies) 	20% coinsurance	20% coinsurance	20% coinsurance	10% coinsurance
<ul style="list-style-type: none"> Podiatry services <ul style="list-style-type: none"> Treatment of injuries and diseases of the feet (e.g., hammer toe, heel spurs) Routine foot care for members with certain medical conditions affecting the lower limbs 	\$30 co-pay	\$35 co-pay	\$30 co-pay	\$15 co-pay
<ul style="list-style-type: none"> Chiropractic services - covers visits for manual manipulation of the spine to correct subluxation. Must use a Chiropractic Care of Minnesota, Inc. network provider to receive this benefit (see the Chiropractic section of the <i>UCare for Seniors</i> Provider and Pharmacy Directory for a complete listing). 	Paid in full	Paid in full	Paid in full	Paid in full

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Worldwide Emergency Care and Urgently Needed Care

Emergency care – inside and outside the service area

- Co-pay is waived if member is admitted to the hospital within 24 hours for the same condition.

\$65 co-pay

\$65 co-pay

\$65 co-pay

\$65 co-pay

Urgently needed care – inside and outside the service area

\$25 co-pay

\$25 co-pay

\$25 co-pay

\$20 co-pay

Ambulance Services

• Includes air (fixed wing, rotary wing) and ground ambulance if transport and level of service are medically necessary, within the United States.

\$100 co-pay per Medicare-allowed ambulance trip

\$100 co-pay per Medicare-allowed ambulance trip

\$100 co-pay per Medicare-allowed ambulance trip

\$100 co-pay per Medicare-allowed ambulance trip

Point-of-Service Benefit (Out-of-network non-urgent or non-emergency services)

Services obtained outside the *UCare for Seniors* network without a referral from the primary care clinic, anywhere in the United States from a Medicare provider (e.g., doctor office visits, diagnostic tests, x-rays, lab services).

The Point-of-Service benefit may not be used for chiropractic services, transplants, dental services, and outpatient prescription drugs.

Contact UCare for a complete list of covered services.

20% coinsurance until a \$20,000 member out-of-pocket maximum in a calendar year

There is also a \$100,000 plan benefit maximum in a calendar year specific to this benefit

20% coinsurance until a \$20,000 member out-of-pocket maximum in a calendar year

There is also a \$100,000 plan benefit maximum in a calendar year specific to this benefit

20% coinsurance until a \$20,000 member out-of-pocket maximum in a calendar year

There is also a \$100,000 plan benefit maximum in a calendar year specific to this benefit

20% coinsurance until a \$20,000 member out-of-pocket maximum in a calendar year

There is also a \$100,000 plan benefit maximum in a calendar year specific to this benefit

Diabetes Care

• Includes coverage for glucose monitors, test strips, and lancets

Note: Per Medicare guidelines, insulin and syringes are covered under Medicare Part D.

Paid in full

20% coinsurance

Paid in full

Paid in full

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Vision Services

<ul style="list-style-type: none"> • Routine eye exam (one per calendar year) 	Paid in full	Paid in full	Paid in full	Paid in full
<ul style="list-style-type: none"> • Diagnostic eye exams for diseases and conditions of the eye (For surgical coverage, see outpatient care and/or inpatient hospital care sections for applicable co-pays) 	\$30 co-pay	\$35 co-pay	\$30 co-pay	\$15 co-pay
<ul style="list-style-type: none"> • Eyewear <ul style="list-style-type: none"> – Basic lenses and frames (one pair per year) 	Not covered	Not covered	Not covered	\$75 annual plan benefit maximum at any provider
<ul style="list-style-type: none"> <ul style="list-style-type: none"> – Contact lenses/exams 	Not covered	Not covered	Not covered	\$75 annual lens plan benefit maximum, in lieu of glasses, at any provider
<ul style="list-style-type: none"> • Postcataract surgery materials <ul style="list-style-type: none"> – Eyeglass lenses or contact lens (per operative eye). <u>Must see a participating provider for eyeglass lenses.</u> 	No co-pay for one pair of conventional eyeglass lenses furnished after each cataract surgery during which an intraocular lens is inserted.	No co-pay for one pair of conventional eyeglass lenses furnished after each cataract surgery during which an intraocular lens is inserted.	No co-pay for one pair of conventional eyeglass lenses furnished after each cataract surgery during which an intraocular lens is inserted.	No co-pay for one pair of conventional eyeglass lenses furnished after each cataract surgery during which an intraocular lens is inserted.
<ul style="list-style-type: none"> <ul style="list-style-type: none"> – Corrective lenses needed after a cataract removal without a lens implant 	Paid in full	Paid in full	Paid in full	Paid in full

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Hearing Services

<ul style="list-style-type: none"> • Routine hearing test (one per calendar year) 	Paid in full	Paid in full	Paid in full	Paid in full
<ul style="list-style-type: none"> • Diagnostic hearing exams 	Paid in full	\$35 co-pay	Paid in full	Paid in full
<ul style="list-style-type: none"> • Hearing aid benefit – used toward hearing aids, repairs, and fittings (covers inner ear, outer ear, or over-the-ear hearing aids). Does not include hearing aid molds, supplies, and batteries. Specific reimbursement instructions can be obtained from UCare’s Customer Services Department at the number on page 2 prior to purchase. 	Not covered	Not covered	Not covered	\$500 plan benefit maximum every 36 months

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Dental Services

<ul style="list-style-type: none"> • Preventive Dental <ul style="list-style-type: none"> – Two oral examinations per calendar year – Three cleanings per calendar year – Bitewing X-rays every 12 months – Full-mouth X-rays every 5 years – Topical application of fluoride in conjunction with a routine cleaning only, or topical fluoride varnish application in conjunction with a routine dental examination as deemed necessary by a dental provider (not covered in combination with a cleaning). No frequency limitations for either type of fluoride application. 	Not covered	Not covered	Not covered	Paid in full
	Not covered	Not covered	Not covered	Paid in full
	Not covered	Not covered	Not covered	Paid in full
	Not covered	Not covered	Not covered	Paid in full
	Not covered	Not covered	Not covered	Paid in full

- UCare contracts with DentaQuest. If you receive dental services from a non-DentaQuest licensed provider, you will be responsible for submitting your bills and paying the difference between the dentist's fees and the allowable amount. To request out-of-network reimbursement, please submit a copy of the American Dental Association (ADA) claim form (obtained from your dentist) with your payment receipt to:

DentaQuest
 Attn: *UCare for Seniors*
 Classic – OON
 P.O. Box 396
 Thiensville, WI 53092

TYPES OF HEALTH CARE SERVICES

	Value \$43	Standard D \$54	Value Plus \$84	Classic \$137
<ul style="list-style-type: none"> • <i>UCare Comprehensive Dental</i> – This benefit is optional and only available to Classic members. A separate application is required and is enclosed with this information. 	Not covered	Not covered	Not covered	\$21 per month in addition to the \$137 Classic premium for a total of \$158
– Basic services (e.g., silver or resin fillings, minor procedures)	Not covered	Not covered	Not covered	80% covered
– Endodontics (e.g., root canal treatment)	Not covered	Not covered	Not covered	80% covered
– Periodontics (e.g., gum disease treatment)	Not covered	Not covered	Not covered	80% covered
– Oral/Maxillofacial Surgery (e.g., extractions including pre-/post-operative care)	Not covered	Not covered	Not covered	80% covered
– Restorative services (e.g., crowns and special procedures)	Not covered	Not covered	Not covered	50% covered
– Prosthodontics – removable and fixed (e.g., bridges; partial/full dentures; repairs and adjustments)	Not covered	Not covered	Not covered	50% covered

Note:

- With the *UCare Comprehensive Dental* plan, there is a \$25 deductible per covered person, per calendar year. In addition, the annual coverage maximum is \$1,000 per covered person, per calendar year.
- You can enroll in the *UCare Comprehensive Dental* plan when you first join the Classic plan and throughout the first month of enrollment. If you do not join at that time, you have to wait to apply between October 15 through December 7 for coverage starting January 1 of the following year. A separate enrollment form is required. Personal scheduling assistance is provided through our See-A-Dentist Appointment Hotline at 1-800-235-0564 (toll free) or TTY at 1-800-466-7566 (toll free). Hours of service are 8 a.m.-5 p.m., Monday through Friday.

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Mental Health and Substance Abuse Care

• Inpatient mental health care	100% after a \$300 co-pay per inpatient admission. There is a 190-day lifetime limit in a psychiatric hospital.	100% after a \$500 co-pay per inpatient admission. There is a 190-day lifetime limit in a psychiatric hospital.	100% after a \$300 co-pay per inpatient admission. There is a 190-day lifetime limit in a psychiatric hospital.	100% after a \$150 co-pay per inpatient admission. There is a 190-day lifetime limit in a psychiatric hospital.
• Outpatient mental health care	\$30 co-pay	\$35 co-pay	\$30 co-pay	\$15 co-pay
• Outpatient substance abuse care	\$25 co-pay	\$35 co-pay	\$25 co-pay	Paid in full
• Inpatient substance abuse care	100% after a \$300 co-pay per inpatient admission	100% after a \$500 co-pay per inpatient admission	100% after a \$300 co-pay per inpatient admission	100% after a \$150 co-pay per inpatient admission

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Skilled Nursing Facility Care

- Semiprivate room and necessary skilled medical services at network facilities; private rooms are covered if medically necessary
- Regular nursing services
- Physical therapy, occupational therapy, and speech-language pathology
- Drugs, medical equipment, and supplies

This benefit is strictly limited to those services specified in Medicare regulations.

\$0 co-pay per day for days 0-20;
\$125 co-pay per day for days 21-100 per benefit period following Medicare guidelines, deemed medically necessary, and provided by a network provider.

No prior hospitalization is required

\$0 co-pay per day for days 0-20;
\$125 co-pay per day for days 21-100 per benefit period following Medicare guidelines, deemed medically necessary, and provided by a network provider.

No prior hospitalization is required

\$0 co-pay per day for days 0-20;
\$125 co-pay per day for days 21-100 per benefit period following Medicare guidelines, deemed medically necessary, and provided by a network provider.

No prior hospitalization is required

\$0 co-pay per day for days 0-20;
\$75 co-pay per day for days 21-100 per benefit period following Medicare guidelines, deemed medically necessary, and provided by a network provider.

No prior hospitalization is required

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Home Health Care

- Skilled medical services by a Medicare-certified home health care agency when you are home-bound
- Necessary supplies and equipment for the treatment of an injury or illness
- Part-time intermittent skilled nursing and home health aide services
- Medical social services

This benefit is strictly limited to those services specified in Medicare regulations.

Paid in full

Paid in full

Paid in full

Paid in full

Hospice

You must receive care from a Medicare-certified hospice.

You must receive care from a Medicare-certified hospice.

You must receive care from a Medicare-certified hospice.

You must receive care from a Medicare-certified hospice.

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Fitness Programs

UCan!SM UCare Activity Network

You have three great fitness options. Choose any or all of them to be active and feel great!

• Health Club Savings

UCare for Seniors members who belong to a participating health club can receive a reduction of up to \$15 in their health club membership fees each month.

Participating health clubs:

- Anytime Fitness*
- Curves*
- Fitness 19*
- Healthy Contributions clubs
- Life Time Fitness
- National Independent Health Club Association (NIHCA) member clubs
- Snap Fitness
- YMCAs of Minneapolis and St. Paul
- YMCA branches in Greater Minnesota and Wisconsin

Additional health clubs may be added. Visit www.ucare.org to see the most current club list.

* *Participating locations only.*

• EnhanceFitness® Classes

Offered at no charge to UCare for Seniors members.

EnhanceFitness offers lively and interactive classes at community locations. They are proven to safely improve strength and fitness in older adults. Classes are led by highly-trained instructors, so you get the results you want. For a list of class locations, go to www.ucare.org.

Included

Included

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Included

TYPES OF HEALTH CARE SERVICES

	Value \$43	Standard D \$54	Value Plus \$84	Classic \$137
<p>• Do-It-Yourself Kit Do-It-Yourself Kit contains a set of portable exercise gear and is available to each member for just \$10. (One additional kit can be purchased for \$40.) The kit includes tools for strength and conditioning for older adults. Members have choices of kit contents:</p> <ul style="list-style-type: none"> • High-end pedometer • Resistance band or tubing • First Step to Active Health activity program booklet instructions • DVD aimed at older adults • A UCare Activity Log Book as a goal-setting tool 	\$10 for first kit	\$10 for first kit	\$10 for first kit	\$10 for first kit
Resources to Stop Using Tobacco				
<i>UCare for Seniors</i> members can access smoking cessation help through the Mayo Clinic Tobacco Quitline at no cost.	Paid in full	Paid in full	Paid in full	Paid in full
Health Connection Nurse Line				
<p>• For reliable health information 24 hours a day, you can call the nurses at Health Connection. They can offer health advice when you are not feeling well and/or answer your health questions. <i>UCare for Seniors</i> members should call 1-888-778-8204 toll free. TTY/hearing impaired: 1-877-728-3311 toll free.</p>	Paid in full	Paid in full	Paid in full	Paid in full

TYPES OF HEALTH CARE SERVICES

Value \$43

Standard D \$54

Value Plus \$84

Classic \$137

Out-of-Pocket Maximum

This is a limit on how much you have to pay out-of-pocket for Medicare-covered services each year. Excludes Medicare Part D, Point-of-Service, eyewear, hearing aids, and dental.

\$3,400 out-of-pocket maximum in a calendar year. You are covered at 100% for benefits for the remainder of the calendar year.

\$3,400 out-of-pocket maximum in a calendar year. You are covered at 100% for benefits for the remainder of the calendar year.

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\$3,400 out-of-pocket maximum in a calendar year. You are covered at 100% for benefits for the remainder of the calendar year.

Enrolling in UCare for Seniors

When can I join, change, or leave Medicare health plans?

There are some limits to when and how often you can change your Medicare health plan. The timeframes during which you can change are called “election periods.” An election period is needed to enroll in, or voluntarily disenroll from, a Medicare Advantage plan. Some of the most common election periods are defined as follows:

- **Annual Opportunity to Review/Change Plans**

Every year during the Annual Election Period (AEP), people on Medicare can change from one way of getting Medicare to another. The AEP timeframe extends from October 15 through December 7. This election allows you to change plans, including adding or dropping Medicare Part D. Any plan switch you make will be effective on January 1 of the following year.

- **For People Newly Eligible for Medicare**

At any time during the year, if you become eligible for Medicare (either by age or disability), you are allowed an election to enroll in a Medicare Advantage Plan during the Initial Coverage Election Period (ICEP). If you take both Part A and Part B when first eligible, this period is a seven month period (the three months before, the month of, and the three months after you become eligible). If you have had Part A and are just applying for Part B, this period is limited to the three months prior to your enrollment in Part B.

- **For Residents of Institutions (e.g., skilled nursing facilities or nursing homes)**

Medicare allows you to enroll in or disenroll from a Medicare Advantage plan effective on the 1st of any month during the year using an election called the Open Enrollment Period – Institutionalized (OEP-I). An institutionalized individual is an individual who moves into, resides in, or moves out of an institution as defined by Medicare. This election ends two months after the month the individual moves out of the institution.

- **Other Special Situations when Medicare Allows Beneficiaries to Change Plans**

Medicare created special election periods for specific situations that occur throughout the year that may result in the need for a Medicare beneficiary to change plans. Although there are more than twenty types of special election periods,

a few of the most common include:

- For a person leaving or losing an employer group or union plan.
- For a person who makes a permanent move if new plan options are available in the new area.
- For a person who qualifies for Extra Help for Medicare Part D.
- For a person on a Medicare health plan that is not renewed or is terminated.
- For a person who is on Medical Assistance or loses eligibility for this program.
- For a person who involuntarily loses other creditable drug coverage (except if due to failure to pay premium).

Certain timeframes and limitations apply to each of the above. These special election periods are in addition to other election periods. Contact the UCare Sales Department at the number on page 2 if you want more information on these exceptions.

How do I enroll?

You can enroll by either completing the enrollment form included in your UCare packet or online at www.ucare.org. Medicare beneficiaries may also enroll in our plan through the Centers for Medicare & Medicaid Services Online Enrollment Center located at www.medicare.gov. For more information, contact the UCare for Seniors Sales Department at the number on page 2.

Fill in the requested Medicare information on the enrollment form exactly as it appears on your Medicare card. If you or your spouse are currently applying for Medicare Part B benefits and received a Medicare Part B benefit verification letter from Social Security, please include a copy with your enrollment form.

If you and your spouse are both enrolling, please complete two forms (one for each of you). A postage-paid envelope is provided for your convenience. You may also fax your enrollment form(s) to 612-676-6562.

How do I pay for the plan?

You can pay your monthly premium by check, by automatic payment, or by automatic withdrawal from your Social Security or Railroad Retirement Board benefit check. You do not need to send money with your enrollment form.

Check

You will receive your monthly billing statement around the 20th of each month for the next coverage month. However, if we receive your enrollment form after the billing cycle has occurred, your first bill will come around the 20th of the month following your effective date of coverage. This bill will be for the first two months of coverage. After that, you will receive a monthly bill. You can also pay for an extended number of months if you choose (e.g., 3 or 6 months). When you get your monthly bill, multiply your premium by the number of months you wish to pay and send it in.

Automatic Payment

You can pay your monthly premium by automatic payment. With this option, your premium is deducted from your checking or savings account between the 7th and 10th of each month. You will not receive any billing statements from UCare (except you may receive one when first enrolling). You will receive an annual notice of your deduction each December. Your premium cannot be charged to a credit card.

Please check the box and complete the account information on the enrollment request form to begin automatic payment.

Social Security or Railroad Retirement Board Withdrawal

You have the opportunity to have your *UCare for Seniors* premium deducted from your Social Security or Railroad Retirement Board benefit check. The deduction may take three months or more to begin. In most cases, the first deduction from your benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. Occasionally there are times when these requests are rejected. If that happens, we may need to bill you monthly until we resubmit your request and it is approved.

If you qualify for Extra Help Medicare Part D, Medicare will cover all or part of your plan premium for Medicare Part D. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

Generally you must stay with the option you choose for the rest of the year. If you do not select a payment option, you will receive a bill each month.

What's next?

Once we receive your enrollment form, you:

- Will receive a call from us if there is any required information missing on the enrollment form. If unable to contact you by phone, we will send you a letter to request the information.
- May receive a letter from us if you did not have a Medicare Part D plan from the date you were first eligible for Medicare Part A or Part B. You will need to indicate any drug coverage you had during this period, sign it, and return it in the postage-paid envelope. You may also respond by phone at 1-877-523-1515 (TTY 1-800-688-2534), 24 hours a day, seven days a week.
- May receive a letter from us if you are leaving an employer group plan to join our plan. Only retirees of employer groups that have special agreements with Medicare related to drug coverage will get this letter. This letter again confirms your intent to leave the group and enroll in our plan. You can either respond by mail or by phone at 1-877-523-1515 (TTY 1-800-688-2534), 24 hours a day, seven days a week.
- Will get a call from us within 15 days to verify your enrollment and answer any questions you may have. If we are unable to reach you, you will receive a letter from us verifying your enrollment.
- Will get a letter confirming your enrollment, once we receive approval from Medicare.
- Will get a new member packet in the mail that contains important information about your coverage, including a detailed description of the benefits in the Evidence of Coverage.
- Will get a UCare member identification card that you can begin using as of your effective date. Should you require medical services or prescription drugs prior to receiving your ID card, please call Customer Services at the phone number below.

Please know that these are all Medicare required mailings and/or calls. If you have questions about any of these mailings, our Customer Services Department is able to assist 24 hours a day, seven days a week. You can reach them at 612-676-3600 or toll free 1-877-523-1515 (TTY 1-800-688-2534).

P.O. Box 52
Minneapolis, MN 55440-0052
612-676-3500
1-877-523-1518 (toll free)
TTY/Hearing impaired
612-676-6810
1-800-688-2534 (toll free)
8 a.m. to 8 p.m.
daily
www.ucare.org

