

Choose the plan that fits your lifestyle

# plan benefit details

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

HEALTH CARE SERVICES	UCARE ESSENTIALS R
2019 monthly premium (you must continue to pay your Medicare Part B premium)	\$68
Medical deductible	\$0
Part D deductible	Tier 1 = \$0 Tiers 2-5 = \$400
<p>Out-of-pocket maximum</p> <p>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.</p>	<p>\$3,400</p> <p>Once you have paid this amount you are covered at 100% for benefits for the remainder of calendar year</p>
<b>Hospital Care</b>	
Inpatient hospital care (per admission)	\$300 copay per day (days 1-5) 100% covered
Outpatient hospital or procedure	\$300 copay
<b>Doctor visits</b>	
Primary	<b>In-network</b> \$20 copay <b>Out-of-network</b> \$20 copay
Specialist	<b>In-network</b> \$45 copay <b>Out-of-network</b> \$45 copay
<b>Preventive care</b>	
Routine physical exam	<b>In-network</b> \$0 copay <b>Out-of-network</b> Not covered
Routine eye exam and hearing test	<b>In-network</b> \$0 copay <b>Out-of-network</b> Not covered
Diabetic retinopathy exam	\$0 copay

Unless otherwise noted above, out-of-network cost-sharing in the U.S. - 20% coinsurance. This does not apply to dental services. See the section on optional dental coverage for more information about out-of-network dental services.

For the next 11 benefits, the \$0 copay applies in-network and out-of-network for all four plans.

"Welcome to Medicare" preventive visit (if in the first 12 months on Part B)	\$0 copay
Annual Wellness Exam (if you had Part B for more than 12 months)	\$0 copay
Immunizations – Flu and pneumonia vaccines. (Shingles vaccine is covered under Medicare Part D.)	\$0 copay
Mammogram screening	\$0 copay
Pap smears and pelvic exams	\$0 copay
Prostate cancer screening exam	\$0 copay
Bone mass measurement	\$0 copay
Diabetes screening	\$0 copay
Preventive colorectal cancer screening	\$0 copay
Cardiovascular screening	\$0 copay
Resources to stop using tobacco	\$0 copay
<b>Emergency/Urgent care at home and while traveling in the United States</b>	
Emergency care – Copay is waived if admitted to the hospital within 24 hours for the same condition; then inpatient hospital copay would apply.	<b>In-network</b> \$100 copay <b>Out-of-network</b> \$100 copay
Urgently needed services – Medically necessary and immediately required as a result of an unforeseen illness, injury or condition.	<b>In-network</b> \$50 copay <b>Out-of-network</b> \$50 copay
<b>Worldwide emergency care</b>	
Applies to care outside the United States and U.S. territories.*	\$100 copay
Ground ambulance for emergency transportation to the nearest appropriate hospital for emergency care.	\$100 copay

**\*Coverage includes**

Services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition.

Post-stabilization, which are services related to an emergency medical condition, provided after stabilization to maintain the condition. Post-stabilization services end at discharge.

HEALTH CARE SERVICES	UCARE ESSENTIALS RX
<b>Miscellaneous Services</b>	
Diagnostic tests (e.g., MRI and CT scans), radiation therapy and X-rays	10% coinsurance up to a maximum of \$75 per day
Lab services (e.g., Protime INR, cholesterol)	<b>In-network</b> \$0 copay <b>Out-of-network</b> \$0 copay
Hearing services	\$45 copay
<b>Preventive Dental Services included in your plan (no additional premium)</b>	
Oral examinations per calendar year	One paid in full
Cleanings per calendar year	One routine paid in full
Bitewing X-rays every 12 months	\$0 copay
Full mouth X-rays every 5 years	Not covered
Topical application of fluoride in conjunction with a routine cleaning or examination.	\$0 copay
<b>Optional dental (For an additional premium you can access more covered services. See section on optional dental coverage.)</b>	
Optional comprehensive dental	<i>Choice Dental</i>
<b>Vision Services</b>	
Routine eye exam You are covered for one routine eye exam and up to two refractions every year	<b>In-network</b> \$0 copay <b>Out-of-network</b> Not covered
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening)	\$45 copay
Eyeglasses or contact lenses after cataract surgery	\$0 copay
Annual allowance for eyeglasses or contacts at any provider	None

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HEALTH CARE SERVICES	UCARE ESSENTIALS RX
<b>Mental Health Services</b>	
Inpatient hospital stay (90 days limit per stay) <ul style="list-style-type: none"> <li>• 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.</li> </ul>	\$300 copay per day (days 1-5); then 100% covered
Outpatient mental health care	<b>In-network</b> \$40 copay <b>Out-of-network</b> \$40 copay
<b>Skilled Nursing Facility Care (or swing bed)^</b>	
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  <b>No prior hospitalization is required*</b>
<b>Other Services</b>	
Physical therapy	<b>In-network</b> \$40 copay <b>Out-of-network</b> \$40 copay
Ambulance <ul style="list-style-type: none"> <li>• Includes air and/or ground if transport and level of service are medically necessary and meet Medicare guidelines.</li> </ul>	<b>In-network</b> \$300 copay <b>Out-of-network</b> \$300 copay
Transportation	Not covered

**\*No prior hospitalization is required** – With all of our UCare Medicare Plan 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.

Unless otherwise noted above, out-of-network cost-sharing in the U.S. - 20% coinsurance. 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

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# prescription drug coverage

HEALTH CARE SERVICES		UCARE ESSENTIALS RX
<b>Medicare Part B Drugs<sup>^</sup></b>		
Generally, drugs that must be administered by a health professional.	20% coinsurance	
<b>Medicare Part D Coverage</b> included with these plan options (no additional premium)		
<b>Annual Deductible Stage</b> – You pay the full cost of your drugs until you reach this amount.	\$400 for Tiers 2-5	
<b>Initial Coverage Stage</b> – From \$0 to \$3,820 in annual prescription drug costs. After you meet the deductible you		
<b>Cost Sharing - Retail:</b> Our network includes preferred pharmacies, which offer lower cost sharing than standard		
<b>Tier 1</b> Preferred generic drugs	<b>Retail</b> - 30 day supply Preferred: \$2 copay Standard: \$12 copay	
<b>Tier 2</b> Generic drugs	<b>Retail</b> - 30 day supply Preferred: \$10 copay Standard: \$20 copay	
<b>Tier 3</b> Preferred brand drugs	<b>Retail</b> - 30 day supply Preferred: \$40 copay Standard: \$47 copay	
<b>Tier 4</b> Non-preferred drugs	<b>Retail</b> - 30 day supply Preferred: 45% coinsurance Standard: 50% coinsurance	
<b>Tier 5</b> Specialty drugs	<b>Retail</b> - 30 day supply Preferred: 25% coinsurance Standard: 25% 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](http://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 UCare Medicare Plans Evidence of Coverage.

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**Coverage Gap Stage**

Once you have reached \$3,820 in annual prescription drug spending (your cost plus UCare's cost), you pay as shown.

You stay in this stage until your out-of-pocket costs reach \$5,100.

*Notes: Your coverage gap is \$5,100 minus the portion of the \$3,820 that you paid out of your own pocket.*

*The size of the coverage gap is NOT \$5,100 minus \$3,820.*

37% of the cost of generic drugs.

25% of the cost of brand-name drugs

**Catastrophic Coverage Stage**

Once you have reached \$5,100 in annual "out-of-pocket" costs, you pay as shown.

**You pay**

The greater of \$3.40 or 5% coinsurance for generic drugs.

The greater of \$8.50 or 5% coinsurance for all other drugs.

## 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.

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# additional benefits

HEALTH CARE SERVICES	UCARE ESSENTIALS RX
<b>Additional Benefits</b>	
Chiropractic services <sup>^</sup> <ul style="list-style-type: none"> <li>Covers visits for manual manipulation of the spine to correct subluxation</li> <li>Must use a ChiroCare network provider</li> </ul>	<b>In-network</b> \$20 copay <b>Out-of-network</b> Not covered
Home health agency care <sup>^</sup>  Skilled medical services by a Medicare-certified home health care agency when you are home bound	\$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
Podiatry services <ul style="list-style-type: none"> <li>Treatment of injuries and diseases of the feet</li> <li>Routine foot care for members with certain medical conditions affecting the lower limbs</li> </ul>	<b>In-network</b> \$45 copay <b>Out-of-network</b> \$45 copay
<b>Supplies</b>	
Hearing aids	Not covered
Durable medical equipment (e.g., oxygen equipment, CPAP) <sup>^</sup>	<b>In-network</b> 20% coinsurance <b>Out-of-network</b> Not covered
Diabetic <ul style="list-style-type: none"> <li>Continuous blood glucose monitors</li> <li>Other glucose monitors</li> <li>Test strips, and lancets</li> </ul> <i>(Insulin and syringes covered under Medicare Part D)</i>	20% coinsurance  20% coinsurance  20% coinsurance
Prosthetic devices (e.g., braces, colostomy bags and supplies)	20% coinsurance

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## UCare Anywhere<sup>SM</sup>

Travel anywhere within the U.S. and pay only your in-network copay on routine care, including You may see any provider that accepts Medicare. UCare will also cover 80% of many other

### Fitness Programs

UCare offers two different fitness options to choose from to stay active and feel great! The fitness program you

#### Option 1: SilverSneakers® Program

To see a list of participating locations, go to [silversneakers.com](http://silversneakers.com)

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](http://ucare.org/healthwellness)

Up to \$20 per month

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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](http://silversneakers.com) or call 1-888-423-4632, Monday – Friday from 7 am – 7 pm CST.

