UCare Advocate and UCare Medicare Plans

2025 Comparison Chart

Metro

	UCare Advocate Choice	UCare Advocate Plus	UCare Aware	UCare Essentials Rx	UCare Complete	UCare Classic	UCare Your Choice	UCare Your Choice Plus
2025 monthly plan premium (you must continue to pay your Medicare Part B premium)	$0	$15	$6.90	$20	$93	$156	$0	$51
Medicare Part B premium giveback	None	None	$20	None	None	None	$24	None
Medicare Part D deductible	Tier 1 & 2 = $0 Tiers 3 – 5 = $125	Tiers 1 – 5 = $0	Tier 1 = $0 Tiers 2 – 5 = $295	Tiers 1 & 2 = $0 Tiers 3 – 5 = $295	Tiers 1 & 2 = $0 Tiers 3 – 5 = $235	Tiers 1 – 5 = $0	Tiers 1 – 5 = $0	Tiers 1 – 5 = $0
Maximum out-of-pocket	$4,500, then 100% covered	$3,850, then 100% covered	$5,400, then 100% covered	$3,800, then 100% covered	$3,000, then 100% covered	$2,800, then 100% covered	$4,900 combined in- and out-of-network, then 100% covered	$3,000 combined in- and out-of-network, then 100% covered
Hospital care								
Inpatient hospital	$0 copay days 1 – 5, $275 per **day,** days 6 – 10, then 100% covered	$0 copay days 1 – 5, $250 per **day,** days 6 – 10, then 100% covered	$250 copay per **day,** days 1 – 5, then 100% covered	$400 copay per **stay,** not per day	$150 copay per **stay,** not per day	$125 copay per **stay,** not per day	**In-network** $350 copay per **day,** days 1 – 5, then 100% covered **Out-of-network** $500 copay per **day,** days 1 – 5, then 100% covered	**In-network** $200 copay per **stay,** not per day **Out-of-network** $800 copay per **stay,** not per day
Observation stay	$275 copay	$250 copay	$250 copay	$300 copay	$250 copay	$150 copay	**In-network** $400 copay **Out-of-network** $600 copay	**In-network** $200 copay **Out-of-network** $300 copay
Outpatient hospital	$275 copay	$250 copay	$300 copay	$300 copay	$250 copay	$150 copay	**In-network** $400 copay **Out-of-network** $600 copay	**In-network** $200 copay **Out-of-network** $300 copay
Ambulatory surgery center	$275 copay	$250 copay	$275 copay	$275 copay	$225 copay	$125 copay	**In-network** $375 copay **Out-of-network** $600 copay	**In-network** $175 copay **Out-of-network** $300 copay
Doctor visits								
Primary	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Specialist	$0 copay in facility where member lives $45 copay outside of facility where member lives	$0 copay in facility where member lives $40 copay outside of facility where member lives	$45 copay	$45 copay	$30 copay	$20 copay	$40 copay	$30 copay

	UCare Advocate Choice	UCare Advocate Plus	UCare Aware	UCare Essentials Rx	UCare Complete	UCare Classic	UCare Your Choice	UCare Your Choice Plus
Preventive care For the next five rows, the $0 copay applies in-network and out-of-network unless otherwise indicated.								
Routine physical exam	n/a	n/a	**In-network** $0 copay **Out-of-network** Not covered	**In-network** $0 copay **Out-of-network** Not covered	**In-network** $0 copay **Out-of-network** Not covered	**In-network** $0 copay **Out-of-network** Not covered	$0 copay	$0 copay
"Welcome to Medicare" preventive visit	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Annual wellness exam	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Immunizations	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Mammogram screening, etc.	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Emergency/urgent care								
Emergency care	$90 copay	$90 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay
Ambulance	$275 copay	$250 copay	$275 copay	$250 copay	$275 copay	$225 copay	$300 copay	$275 copay
Urgently needed services	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay	$45 copay
Diagnostic tests, radiation therapy, X-rays and lab services								
Diagnostic tests	20% coinsurance	20% coinsurance, up to a maximum of $75 per day	20% coinsurance, up to a maximum of $75 per day	10% coinsurance, up to a maximum of $75 per day	10% coinsurance, up to a maximum of $75 per day	$0 copay	**In-network** $25 copay **Out-of-network** 30% coinsurance	**In-network** $20 copay **Out-of-network** 30% coinsurance
X-rays, MRIs and CT scans	20% coinsurance	20% coinsurance, up to a maximum of $75 per day	20% coinsurance, up to a maximum of $75 per day	10% coinsurance, up to a maximum of $75 per day	10% coinsurance, up to a maximum of $75 per day	$0 copay	**In-network** $25 – $100 copay **Out-of-network** 30% coinsurance	**In-network** $15 – $75 copay **Out-of-network** 30% coinsurance
Lab and bloodwork	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

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Hearing services								
Hearing exams	20% coinsurance $0 copay for routine exams	20% coinsurance $0 copay for routine exams	$45 copay $0 copay for routine exams	$45 copay $0 copay for routine exams	$30 copay $0 copay for routine exams	$20 copay $0 copay for routine exams	$40 copay $0 copay for routine exams	$30 copay $0 copay for routine exams
TruHearing® aids	$400 hearing aid allowance $0 copay for unlimited fittings	$550 hearing aid allowance $0 copay for unlimited fittings	$699 copay for Advanced $999 copay for Premium $0 copay for unlimited fittings	$699 copay for Advanced $999 copay for Premium $0 copay for unlimited fittings	$599 copay for Advanced $899 copay for Premium $0 copay for unlimited fittings	$499 copay for Advanced $799 copay for Premium $0 copay for unlimited fittings	$1,200 flexible benefit allowance for dental, hearing aids and prescription eyewear, no network	$1,600 flexible benefit allowance for dental, hearing aids and prescription eyewear, no network
Dental services								
Dental services	Up to $1,325 per year for medically necessary non-cosmetic, non-experimental dental services not covered by Medicare	Up to $1,125 per year for medically necessary non-cosmetic, non-experimental dental services not covered by Medicare	$600 yearly allowance	Routine dental with optional coverage available	Routine and restorative dental coverage at no additional cost	Routine dental with optional coverage available	$1,200 flexible benefit allowance for dental, hearing aids and prescription eyewear, no network	$1,600 flexible benefit allowance for dental, hearing aids and prescription eyewear, no network
Vision services								
Vision services	20% coinsurance $0 copay for routine exams $200 annual eyewear allowance	20% coinsurance $0 copay for routine exams $225 annual eyewear allowance	$45 copay $0 copay for routine exams $150 annual eyewear allowance	$45 copay $0 copay for routine exams $150 annual eyewear allowance	$30 copay $0 copay for routine exams $200 annual eyewear allowance	$20 copay $0 copay for routine exams $200 annual eyewear allowance	$40 copay $0 copay for routine exams $1,200 flexible benefit allowance for dental, hearing aids and prescription eyewear, no network	$30 copay $0 copay for routine exams $1,600 flexible benefit allowance for dental, hearing aids and prescription eyewear, no network
Mental health services								
Inpatient mental health	$0 copay, days 1 – 5 $275 per **day,** days 6 – 10 $0 copay per **day,** days 11 – 90 $0 copay, lifetime reserve days	$0 copay, days 1 – 5 $250 per **day,** days 6 – 10 $0 copay per **day,** days 11 – 90 $0 copay, lifetime reserve days	$250 copay per **day,** days 1 – 5, then 100% covered	$400 copay per **stay,** not per day	$150 copay per **stay,** not per day	$125 copay per **stay,** not per day	**In-network** $350 copay per **day,** days 1 – 5, then 100% covered **Out-of-network** $500 copay per **day,** days 1 – 5, then 100% covered	**In-network** $200 copay per **stay,** not per day, then 100% covered **Out-of-network** $800 copay per **stay,** not per day, then 100% covered
Outpatient mental health	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

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Skilled nursing facility								
Skilled nursing facility[1] (does not require a 3-day hospital stay, amounts shown are per benefit period)	100 days covered $0 copay per day, days 1 – 20 $170 copay per day, days 21 – 100	100 days covered $0 copay per day, days 1 – 20 $170 copay per day, days 21 – 100	$0 copay per day, days 1 – 20 $214 copay per day, days 21 – 100	$0 copay per day, days 1 – 20 $214 copay per day, days 21 – 100	$0 copay per day, days 1 – 20 $214 copay per day, days 21 – 100	$0 copay per day, days 1 – 20 $100 copay per day, days 21 – 100	**In-network** $0 copay per day, days 1 – 20 $214 copay per day, days 21 – 100 **Out-of-network** 30% coinsurance	**In-network** $0 copay per day, days 1 – 20 $214 copay per day, days 21 – 100 **Out-of-network** 30% coinsurance
Other services								
Physical therapy[1]	$30 copay	$20 copay	$40 copay	$40 copay	$30 copay	$20 copay	$40 copay	$30 copay
Transportation	$500 annual allowance for rides to approved locations within service area	$500 annual allowance for rides to approved locations within service area	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Medicare Part B drugs[2]	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	**In-network** 20% coinsurance **Out-of-network** 30% coinsurance	**In-network** 20% coinsurance **Out-of-network** 30% coinsurance

[1]Service requires prior authorization.

[2]Service requires prior authorization. Certain drugs may have a lower coinsurance. You will not pay more than $35 for a one-month supply of Part B insulin.

	UCare Advocate Choice	UCare Advocate Plus	UCare Aware	UCare Essentials Rx	UCare Complete	UCare Classic	UCare Your Choice	UCare Your Choice Plus
Medicare Part D coverage								
Cost sharing for deductible: You pay the full cost of your drugs until you reach this amount	Tiers 1 & 2 = $0 Tiers 3 – 5 = $125	Tiers 1 – 5 = $0	Tier 1 = $0 Tiers 2 – 5 = $295	Tiers 1 & 2 = $0 Tiers 3 – 5 = $295	Tiers 1 & 2 = $0 Tiers 3 – 5 = $235	Tiers 1 – 5 = $0	Tiers 1 – 5 = $0	Tiers 1 – 5 = $0
Initial coverage phase: You stay in this phase until you reach the $2,000 out-of-pocket maximum. After you meet the deductible, you pay the amounts listed below.								
Tier 1 Preferred generic drugs	$3 copay	$2 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 Generic drugs	$15 copay	$12 copay	$10 copay	$10 copay	$10 copay	$7 copay	$12 copay	$10 copay
Tier 3 Preferred brand drugs Insulin: $35 copay, no deductible	$47 copay	$47 copay	$47 copay	$47 copay	$47 copay	$35 copay	$47 copay	$47 copay
Tier 4 Non-preferred drugs Insulin: $35 copay, no deductible	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay
Tier 5 Specialty drugs	31% coinsurance	33% coinsurance	29% coinsurance	29% coinsurance	30% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Catastrophic coverage								
Once you have reached $2,000 in annual prescription drug spending (excluding UCare's cost), you pay $0	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

Cost sharing may differ based on whether the prescription is short-term (30-day supply) or extended day (up to 100-day supply as prescribed by your provider).

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/advocate** 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 Evidence of Coverage.

Medicare Prescription Payment Plan

Members with Part D coverage can enroll in the Medicare Prescription Payment Plan at no additional cost. This program allows you to pay your out-of-pocket prescription drug costs monthly instead of paying at the pharmacy. If you sign up, you'll get a monthly bill from UCare for your medications.

If you have Medicare or are Medicare eligible, consider UCare Advocate Choice & UCare Advocate Plus. If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare & You handbook. View online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users call 1-877-486-2048.

UCare Advocate Plans are Institutional Special Needs Plans (HMO I-SNP). UCare Advocate Choice and UCare Advocate Plus (HMO I-SNP) are Medicare Advantage Institutional Special Needs Plans for Minnesota adults living in a nursing home, assisted living or memory care facility.

UCare is an HMO-POS/I-SNP/PPO plan with a Medicare contract. Enrollment in UCare depends on contract renewal.

Call a UCare agent for help enrolling over the phone at 1-877-671-1054. TTY users call 1-800-688-2534.

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