2024 Summary of Benefits

Medicare Advantage Plans Comparison Guide

ASPIRUS® HEALTH PLAN

Enrollment

Choose a clinic

Select a primary care clinic from the Primary Care Clinic Listing found in your plan information kit. 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 receive 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 Aspirus Health Plan 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 Service at 1.855.931.4850 (TTY users call 1.855.931.4852).

How to pay your premiums

You can choose to pay your monthly premium:

- By check
- Automatic payment/Electronic Funds Transfer (EFT)
- Social Security or Railroad Retirement Board withdrawal
- Aspirus online member account

Please do not send payment with your enrollment form.

How to enroll

by mail

Fill out the enrollment form and mail in the postage-paid envelope.

Download enrollment form at **medicare.aspirushealthplan.com,** fill out and mail to:

ATTN: Medicare Sales
Aspirus Health Plan
P.O. Box 51
Minneapolis, MN 55440

phone

Call 1.855.931.4859 to enroll with a licensed Medicare Sales Specialist
8 am – 8 pm, seven days a week (Oct. 1 – March 31),
8 am – 8 pm, Monday – Friday (April 1 – Sept. 30).

Call a trusted representative near you.

Coverage in Wisconsin and beyond

Aspirus Health Plan Medicare Advantage Plans

- Essential Rx (PPO*)
- Elite (PPO*)

Care from a network you trust

When you choose Aspirus Health Plan, you're teaming up with your local health system. We work together with Aspirus Health to help you get quality care and excellent service, and we have strong ties to your community. So chances are, you're already familiar with the doctors and clinics in our network.

- Local health system committed to serving central Wisconsin
- Easy access to Aspirus Health doctors, clinics and hospitals with no referrals required

Find a provider at **search.aspirushealthplan.com.**

See any provider that accepts Medicare.

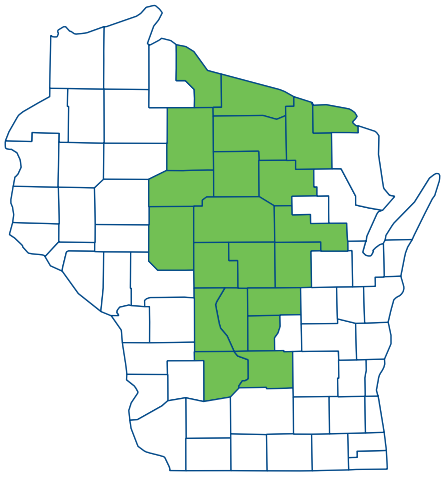
Pay less when you get care from network providers.

1,100+ clinics

20+ hospitals

Our Medicare Advantage plans are available in 21 Wisconsin counties

Adams, Clark, Columbia, Florence, Forest, Iron, Juneau, Langlade, Lincoln, Marathon, Marquette, Oneida, Portage, Price, Sauk, Shawano, Taylor, Vilas, Waupaca, Waushara, and Wood



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), and are a citizen and a permanent resident of the United States. To join Aspirus Health Plan Medicare Advantage Plans, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area, shown on the map above.

This booklet gives you a summary of what each plan covers. It doesn't list every service we cover or every limitation or exclusion that may apply. Some services require prior authorization. To get a complete list of covered services, call and ask us for the Evidence of Coverage. This information is not a complete description of benefits. Call 1.855.931.4859 or 1.855.931.4852 (TTY) for more information.

*PPO: Preferred Provider Organization

Plan benefit details

As an Aspirus Health Plan member, you are free to see an in-network or an out-of-network provider. If you see an out-of-network provider your costs may be higher. In general, out-of-network cost-sharing in the U.S. is 30%. However, for some services the copay is the same whether you see an in-network or an out-of-network provider (e.g. primary and specialist doctor visits).

Note: If you see an out-of-network provider, be sure they participate in Medicare. Aspirus Health Plan cannot cover care costs from out-of-network providers who don't contract with Medicare. The only exception to this rule is for emergency care.

	Essential Rx		Elite	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
2024 monthly premium (You must continue to pay your Medicare Part B premium)	$0		$0	
Medicare Part B premium giveback (per month)	Not applicable		$25	
Medical deductible	$0		$0	
Medicare Part D deductible	Tiers 1 & 2 = $0 Tiers 3 – 5 = $245		Not covered	
Maximum out-of-pocket The most you will pay out-of-pocket for both in-network and out-of-network Medicare-covered services, combined each year. Excludes Medicare Part D and all other non-Medicare covered services and premium. **This is not your deductible.**	$4,500		$3,200	
Hospital Care				
Inpatient hospital care (per admission)	$400 copay per **stay;** then 100% covered	30% coinsurance	$300 copay per **stay;** then 100% covered	30% coinsurance
Outpatient hospital care (per admission)	$295 copay	30% coinsurance	$195 copay	30% coinsurance
Ambulatory surgery center	$295 copay	30% coinsurance	$195 copay	30% coinsurance

	Essential Rx		Elite	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Doctor Visits — In-person or telehealth for Medicare-approved services				
Primary	$0 copay		$0 copay	
Specialist	$40 copay		$40 copay	
E-visits through Virtuwell™	$0 copay		$0 copay	
Preventive Care				
Routine physical exam	$0 copay	30% coinsurance	$0 copay	30% coinsurance
"Welcome to Medicare" preventive visit (if in the first 12 months on Part B)	$0 copay		$0 copay	
Annual Wellness Exam (if you've had Part B for more than 12 months)	$0 copay		$0 copay	
Flu and pneumonia vaccines	$0 copay		$0 copay	
Mammogram screening, prostate cancer screening exam, bone mass measurement, diabetes screening, preventive colorectal cancer screening	$0 copay		$0 copay	
Emergency / Urgent Care — Network does not apply				
Emergency care	$100 copay		$100 copay	
Urgently needed services	$25 copay		$25 copay	

	Essential Rx		Elite	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Diagnostic Tests, Radiation Therapy, X-rays and Lab Services				
Diagnostic tests	20% coinsurance up to a maximum of $125 per day	30% coinsurance	$0 copay	30% coinsurance
X-rays, MRI and CT scans, radiation therapy	20% coinsurance up to a maximum of $125 per day	30% coinsurance	20% coinsurance up to a maximum of $125 per day	30% coinsurance
Diagnostic mammograms	$0 copay	30% coinsurance	$0 copay	30% coinsurance
Lab services (e.g., Protime INR, cholesterol)	$0 copay		$0 copay	
Hearing Services				
Diagnostic hearing exam	$45 copay	30% coinsurance	$40 copay	30% coinsurance
Annual routine hearing exam, hearing aid fitting and evaluation through TruHearing®	$0 copay	30% coinsurance	$0 copay	30% coinsurance
TruHearing aids in both Advanced and Premium models (two different copay amounts, two aids per year)	$699 copay Advanced Aid $999 copay Premium Aid		$599 copay Advanced Aid $899 copay Premium Aid	

	Essential Rx		Elite	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Dental Coverage				
Coverage includes	Routine dental with optional coverage available		Routine dental with optional coverage available	
Optional coverage premium	**+ $25** per month		**+ $25** per month	
Deductible	$75 per year	If your dental services are performed by a dentist outside of the Delta Dental National Medicare Advantage network (must be within the United States and its territories), you will be responsible for paying the difference between the dentist's fees and the Aspirus dental fee schedule.	$75 per year	If your dental services are performed by a dentist outside of the Delta Dental National Medicare Advantage network (must be within the United States and its territories), you will be responsible for paying the difference between the dentist's fees and the Aspirus dental fee schedule.
Annual plan maximum	$2,000		$2,000	
Oral examinations	One per year[1] (two total with purchase of optional coverage)		One per year[1] (two total with purchase of optional coverage)	
X-rays	Annual bitewing[1] (full mouth every 5 years with purchase of optional coverage)		Annual bitewing[1] (full mouth every 5 years with purchase of optional coverage)	
Fluoride treatment	Covered[1]		Covered[1]	
Periodontal maintenance cleanings	One per year[1] (unlimited with purchase of optional coverage)		One per year[1] (unlimited with purchase of optional coverage)	
Basic restorative services (e.g., fillings, root canals, periodontal services)	30% coinsurance with purchase of optional coverage		30% coinsurance with purchase of optional coverage	
Major restorative procedures (e.g., crowns, bridges, implants, dentures)	60% coinsurance with purchase of optional coverage		60% coinsurance with purchase of optional coverage	

[1]These services are included without purchase of optional coverage and no deductible applies. These services do not apply to annual plan maximum.

Your cost-sharing is less when you see providers in the Delta Dental Medicare Advantage network. The percentages listed above are the percentages that you pay.

For dental limitations and exclusions, see page 12.

Members must be enrolled in our Medicare plan for 24 consecutive months before plan coverage applies to bridges, dentures, prosthetics and implants. There is no waiting period for other services such as fillings and crowns.

	Essential Rx		Elite	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Vision Services				
Diagnostic eye exam	$45 copay	30% coinsurance	$40 copay	30% coinsurance
Annual routine eye exam and up to two refractions per year	$0 copay	30% coinsurance	$0 copay	30% coinsurance
Diabetic retinopathy exam	$0 copay	30% coinsurance	$0 copay	30% coinsurance
Prescription eyeglasses or contact lenses after cataract surgery	$0 copay	30% coinsurance	$0 copay	30% coinsurance
Annual allowance for prescription eyeglasses or contacts	$250		$175	
Mental Health Services				
Inpatient hospital stay (90-day limit per stay, per admission) Limited to 190 days in a lifetime in a psychiatric hospital	$400 copay per **stay;** then 100% covered	30% coinsurance	$300 copay per **stay;** then 100% covered	30% coinsurance
Outpatient mental health care	$0 copay		$0 copay	
Skilled Nursing Facility Care (or swing bed)[2]				
Care in a skilled nursing facility with **no prior 3-day hospital stay required**	$0 copay per day for days 1 – 20; $203 copay per day for days 21 – 53; $0 copay per day for days 54 – 100; per benefit period	30% coinsurance	$0 copay per day for days 1 – 20; $203 copay per day for days 21 – 43; $0 copay per day for days 44 – 100; per benefit period	30% coinsurance

[2]Service requires prior authorization.

	Essential Rx		Elite	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Other Services				
Physical therapy	$40 copay		$40 copay	
Ambulance (within the U.S. and its territories) Includes air and/or ground	$300 copay		$200 copay	
Transportation (non-emergency)	Not covered		Not covered	
Medicare Part B Drugs[3] Generally, drugs that must be administered by a health professional	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
Chiropractic services through ChiroCare network[4] Manual manipulation of the spine to correct subluxation	$20 copay	30% coinsurance	$10 copay	30% coinsurance
Acupuncture All plans cover acupuncture for chronic low back pain, based on Medicare criteria	Doctor visit copays apply (see page 3)		Doctor visit copays apply (see page 3)	
Podiatry services • Treatment of injuries and diseases of the feet • Routine foot care for members with certain medical conditions affecting the lower limbs	$45 copay		$40 copay	
Over-the-counter (OTC) allowance	$125 allowance twice a year		$75 allowance twice a year	
Durable medical equipment[4] (e.g., oxygen equipment, CPAP)	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance

[3]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.

[4]Service requires prior authorization.

	Essential Rx		Elite	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Other Services continued				
Fitness options	One Pass fitness program		One Pass fitness program	
Prosthetic devices (e.g., braces, colostomy bags and supplies)	20% coinsurance	30% coinsurance	20% coinsurance	30% coinsurance
Diabetic supplies • Continuous blood glucose monitors • Other glucose monitors • Test strips and lancets (Insulin and syringes covered under Medicare Part D)	0% coinsurance 0% coinsurance $0 copay	30% coinsurance	0% coinsurance 0% coinsurance $0 copay	30% coinsurance
Worldwide Emergency Care (outside of the U.S. and its territories)				
Emergency care including post-stabilization	$100 copay		$100 copay	
Ground ambulance to the nearest hospital for emergency care	$300 copay		$200 copay	

Note: Only emergency coverage is worldwide. You may want to consider purchasing a separate travel policy while traveling outside the U.S. for services such as air ambulance.

	Essential Rx	Elite
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 = $245	Medicare Part D drugs are not covered in Elite. Note: You CANNOT be a member of the Elite plan and a standalone Part D plan at the same time. If you want both medical and prescription drug coverage, choose Essential Rx. This plan is designed for those who have drug coverage through the Veteran's Administration or other programs, such as SeniorCare in Wisconsin.
Initial Coverage Phase: From $0 to $5,030 in annual prescription drug costs. After you meet the deductible, you pay the amounts below		
Tier 1 Preferred generic drugs	**Retail** — 30-day supply $0 copay	
Tier 2 Generic drugs	**Retail** — 30-day supply $12 copay	
Tier 3 Preferred brand drugs Insulin: $35 copay, no deductible	**Retail** — 30-day supply $47 copay	
Tier 4 Non-preferred drugs Insulin: $35 copay, no deductible	**Retail** — 30-day supply 50% coinsurance	
Tier 5 Specialty drugs	**Retail** — 30-day supply 29% coinsurance	

Cost-sharing may differ based on pharmacy type or status (mail-order, retail, long term care (LTC), home infusion), or whether the prescription is 30-, 60- or extended supply up to 100 days as prescribed by your provider.

Additional requirements or limits on covered drugs — Some covered drugs may have additional requirements or limits to coverage. Visit **medicare.aspirushealthplan.com** to find out if your drug has any additional requirements or limits. These may include: Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST). You can 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 Aspirus Health Plan Medicare Advantage Plans Evidence of Coverage.

Essential Rx includes Part D and covers most Part D vaccines at no cost to you, even if you haven't met your deductible. This includes the two-part shingles vaccine (SHINGRIX®).

	Essential Rx	Elite
Coverage Gap		Medicare Part D drugs are not covered in Elite. Note: You CANNOT be a member of the Elite plan and a standalone Part D plan at the same time. If you want both medical and prescription drug coverage, choose Essential Rx. This plan is designed for those who have drug coverage through the Veteran's Administration or other programs, such as SeniorCare in Wisconsin.
Once you have reached $5,030 in annual prescription drug spending (your cost plus Aspirus Health Plan's cost), you pay as shown	25% of the cost of generic and brand drugs	
Catastrophic Coverage		
Once you have reached $8,000 in annual prescription drug spending (excluding Aspirus Health Plan's cost), you pay $0	$0 copay	

Extra Help for Medicare 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 users call 1.877.486.2048), 24/7
- Social Security Administration at 1.800.772.1213 (TTY users call 1.800.325.0778), 7 am – 7 pm, Monday – Friday
- Your State Medicaid Office or County Human Services Office
- SeniorCare in Wisconsin at 1.800.657.2038

Some people will pay a higher premium for Medicare Part D coverage because their yearly income is over certain amounts.

To find a pharmacy visit **search.aspirushealthplan.com.** If you prefer, call for help or request a Provider and Pharmacy Directory at 1.855.931.4859.

Additional information

Provider network coverage

While you are a member of our plan, you must use network providers to get your medical care and services covered at in-network cost-share levels. Exceptions to this include emergency care, urgent care, out-of-area dialysis services, lab services, Medicare-covered preventive screenings, and cases in which the plan authorizes use of out-of-network providers. You can obtain certain covered services from out-of-network providers at different cost-share levels.

Out-of-network/non-contracted providers are under no obligation to treat UCare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Case Management

UCare Case Management is a short-term (3 – 6 month) telephonic program for members challenged by multiple chronic health conditions. We offer care management to members with select diagnoses who transition to home from a hospital or skilled nursing facility. The Case Management team consists of registered nurses whose primary focus is on assisting our members with medical case management needs such as health decision support and disease specific education. The case management team also works with internal and external resources to provide the member with needed support and help with attaining best health outcomes. They conduct care management by phone during business hours.

Understanding utilization management

Prior authorization

One way that UCare ensures excellent care is by collaborating with your healthcare professionals to evaluate specific services and procedures. Our goal is to ensure that you receive the best possible care for your individual needs. This Summary of Benefits provides information on the types of care or services that require notification or authorization. It's important to note that this list may change periodically. For instance, some examples of services that require prior approval include spine surgery and home health care.

We offer coverage for certain services listed in the benefits chart only when your doctor or provider obtains advance approval from us. These approved services include inpatient rehabilitation services, genetic and molecular diagnosis tests, lumbar spine surgery, bariatric surgery, vein procedures, bone growth stimulators, and spinal cord stimulators. Other services that require prior authorization and/or notification are marked with a [3, 4, 5] in the chart.

Authorization and notification

One of the ways UCare makes sure you get excellent care is by partnering with your doctors to review certain types of services and procedures. We want you to get the care that is best for your needs.

This Summary of Benefits notes which types of care or services require notification or authorization. This list may change from time to time. Some examples include spine surgery and home health care.

Notification

Hospitals are required to notify UCare if you are admitted to a hospital, long term care facility, or skilled nursing facility. UCare's clinical team will collaborate with your healthcare professionals to ensure you receive the necessary care. If needed, UCare may set up post-hospital care.

Prior authorization/ preservice review

Before any services can be covered, your healthcare provider must obtain approval from UCare. This applies to providers who are part of the UCare network as well as those who are out-of-network. To determine coverage, UCare's clinical team assesses whether the service is medically necessary, appropriate, and effective for your specific needs. Prior authorization, also known as preservice review, requires your provider to submit information to UCare and request approval before you receive the service. If pre-approval is necessary for the specific service, coverage will only be provided if approval has been granted.

Urgent/concurrent review

During your stay in a Long-Term Care Facility or Skilled Nursing Facility, urgent concurrent and concurrent reviews may occur. UCare will assess whether your care needs to continue for a longer duration or if alternative care is necessary.

Post-service review
Post-service review is necessary in case your doctor did not request a pre-service review. It is possible that your claim has already been denied because authorization is required for coverage. Once your doctor submits a review, UCare will carefully evaluate your situation and care plan to ensure that you receive the coverage you are entitled to as a UCare member.

Appeal
If we deny a request made by you or your doctor for medical services or pharmaceuticals, you or your doctor have the option to appeal our decision. At the time of filing an appeal, you or your doctor may include additional documentation that is relevant to your case. Appeal requests undergo a thorough review by physicians, who assess them considering current medical evidence and your benefit plan. If your appeal is turned down, you will receive guidance on how to proceed with a second-level appeal.

Learn more
Go to ucare.org and click on "plan resources." UCare members can also look up services in their Evidence of Coverage and Annual Notice of Changes documents. These documents note if notification and authorization is required. Every renewal year, members receive an Annual Notice of Changes that explains any changes to their plan benefits.

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 such as 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 part. 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 (except some coverage for members with congestive heart failure in UCare Classic)
- 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
- Radial keratotomy, LASIK surgery, vision therapy and other low-vision aids. Eyewear except for one pair of eyeglasses (or contact lenses) after cataract surgery and non Medicare-covered eyewear up to the allowed amount.
- Reversal of sterilization procedures, and/or non prescription contraceptive supplies
- Acupuncture (except for Medicare covered chronic low back pain and additional coverage for UCare Classic members)
- 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.

Dental coverage limitations

Frequency limits and waiting periods do not apply to plans with a yearly dental allowance. Otherwise these limitations apply to all plans.

- Endodontics: Limited to one (1) per tooth per lifetime.
- Periodontics (other than periodontal maintenance cleanings): Coverage is limited to one (1) non-surgical periodontal treatment and one (1) surgical periodontal treatment per quadrant every 36 months.
- Bone grafting: 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 60 month period, measured from the last date the covered dental service was performed.
- Prosthetics — removable and fixed: A prosthetic appliance (denture or bridge) for the purpose of replacing an existing appliance will be covered only after 60 months.
- Implant services: Replacing a single missing tooth. Coverage for implants is limited to once per tooth per lifetime (also see Exclusion #18).

Dental coverage exclusions

These exclusions are specific to dental coverage. Some of these exclusions may be covered under your medical benefit:

1. Dental services that are not necessary or specifically covered
2. Hospitalization or other facility charges
3. Prescription drugs
4. Any dental procedure performed solely as a cosmetic procedure
5. Charges for dental procedures completed prior to the member's effective date of coverage
6. Anesthesiologist services
7. 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
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles, except as provided under Oral Surgery in the Evidence of Coverage
9. Artificial material implanted or grafted into soft tissue, including surgical removal of implants, with exceptions
10. Oral hygiene instruction and periodontal exam
11. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture
12. Any oral surgery that includes surgical endodontics (apicoectomy, retrograde filling) other than that listed under Oral Surgery in the Evidence of Coverage
13. Analgesia (nitrous oxide)
14. Removable unilateral dentures
15. Temporary procedures
16. Splinting
17. Consultations by the treating provider and office visits
18. 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 beencontinuously covered under a UCare Medicare Plan for more than 24 months
19. Occlusal analysis, occlusal guards (night guards) and occlusal adjustments (limited and complete)
20. Veneers (bonding of coverings to the teeth)
21. Orthodontic treatment procedures
22. Corrections to congenital conditions, other than for congenital missing teeth
23. Athletic mouth guards
24. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment, except as noted in the Evidence of Coverage
25. Space maintainers

Notice of privacy practices

Effective Date: July 1, 2013
Date of Last Review: July 20, 2022
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.

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

Questions?
If you have questions or want to file a complaint, you may contact our Privacy Officer at UCare, Attn: Privacy Officer, PO Box 52, Minneapolis, MN 55440-0052, or by calling our 24 hour Compliance Hotline at 612-676-6525. 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.

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, race, ethnicity, language, sexual orientation, gender identity, 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.

We do not use or disclose any genetic information, race, ethnicity, language, sexual orientation or gender identity for the purpose of underwriting.

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 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 and was last revised on July 20, 2022.

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 Service 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.

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 612-676-3200 (voice) or toll free at 1-800-203-7225 (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 612-676-3200 or toll free at 1-800-203-7225 (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 612-676-3200 or toll free at 1-800-203-7225 (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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715-631-7411/1-855-931-4850 (телетайп: 715-631-7413/1-855-931-4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715-631-7411/1-855-931-4850 (መስማት ለተሳናቸው: 715-631-7413/1-855-931-4852).

ဟသျဉ်ဟသး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်ၤ ကျိာ်အတၢ်မၤစၢၤလၢ တလာ်ဘျဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែខ្មរ, រសរាជំនួយរ៉ែផ្នកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 715-631-7411/1-855-931-4850 (TTY715-631-7413/1-855-931-4852)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 715-631-7411/1-855-931-4850 (رقم هاتف الصم والبكم: 715-631-7413/1-855-931-4852.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715-631-7411/1-855-931-4850 (ATS : 715-631-7413/1-855-931-4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

Notes

Choose a plan that's right for you

Charlie

Charlie is active, busy and in great health. He's about to turn 65. He wants to find good coverage in case of an emergency or serious illness. Essential Rx is an ideal choice for Charlie because he is willing to pay more in out-of-pocket costs in exchange for a $0 premium.

Terry

Terry is a veteran who receives most of his care and all of his prescriptions through the VA. Elite gives Terry additional benefits, including dental and fitness, and gives back part of his Medicare Part B premium. Elite is also a good fit for those enrolled in the State Pharmaceutical Assistance Program (e.g., SeniorCare in WI).

	Essential Rx	Elite
Premium (You must continue to pay your Part B premium)	$0	$0
Medicare Part B giveback	**Not applicable**	$25
Medical and hospital	✓	✓
Fitness programs	✓	✓
Dental	✓	✓
Prescription eyewear and hearing aids	✓	✓
Over-the-counter allowance	✓	✓
Medicare Part D prescription drug coverage	✓	**Not applicable**
Coverage when traveling	✓	✓
Maximum out-of-pocket (in- and out-of-network combined)	$4,500	$3,200

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.

Aspirus Health Plan, Inc. is a PPO plan with a Medicare contract. Enrollment in Aspirus Health Plan, Inc. depends on contract renewal.

P.O. Box 51
Minneapolis, MN 55440-9972
715.631.7441 | 1.855.931.4859 | TTY 1.855.931.4852
medicare.aspirushealthplan.com

H6874_50014_082023_M