UCare Medicare Supplement $20/$50 Copay (Plan N)

The Commissioner of Commerce in the State of Minnesota has established two categories of Medicare Supplement insurance, and minimum standards for each. The two categories are "Basic Medicare Supplement" and "Extended Basic Medicare Supplement", with the latter being the more comprehensive of the two. This policy describes your UCare coverage under the Medicare Supplement Plan with $20 and $50 Copayments category. The benefits under this plan constitute a Non-qualified Medicare Supplement plan. Upon your payment of premium and issue of this policy and a UCare identification card, we agree to provide the benefits described in this policy.

NOTICE TO BUYER:

THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

THIS POLICY DOES NOT COVER PRESCRIPTION DRUGS. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask for further details.

YOUR RIGHT TO RETURN THIS POLICY

Please read this policy carefully. This is a legal document between you and us. If you find that you are not satisfied with it for any reason, you can return it to UCare Customer Support P.O. Box 211522, Eagan, MN 55121. If you send it back to us within 30 days after you receive it, we will treat the policy as if it had never been issued. We will refund all payments you have made on it within ten (10) business days after we receive notice of cancellation and the returned policy.

GUARANTEED RENEWABLE FOR LIFE SUBJECT TO TIMELY PAYMENT OF PREMIUM

This policy is guaranteed renewable for life, subject to timely payment of premium, within the grace period. UCare shall neither cancel nor non-renew your policy for any reason other than nonpayment of premium or material misrepresentation. This policy cannot be canceled or non-renewed on the grounds of deterioration of health, or discriminate in the pricing of such coverage because of health status, claims experience, receipt of health care, medical condition, or age, or impose an exclusion of benefits based upon genetic information or a pre-existing condition.

PRE-EXISTING CONDITIONS LIMITATION

This policy contains coverage limitations for pre-existing conditions. Please reference Section IV for more detailed information.

PREMIUM RATE CHANGES

The same rating schedule shall apply to all of our policies with this policy form number, and the same rates shall apply to all participants in the same rating classification, as approved by the Department of Commerce. You will be notified at least thirty (30) days in advance before the change in rates.

Notice: This disclosure is required by Minnesota law. This policy is expected to return on average 73.2% of your premium dollar for health care. The lowest percentage permitted by state law for this policy is 65%.

Beth Monsrud
Senior Vice President and Chief Financial Officer

Ghita Worcester
Senior Vice President, Public Affairs & Chief Marketing Officer

UCare Health, Inc.
500 Stinson Blvd
Minneapolis, MN 55413

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I. DEFINITIONS

Wherever used in this policy, the following terms shall mean:

BENEFIT PERIOD: a benefit period starts with the first full day that you are in a hospital, skilled nursing facility or rehabilitative facility. It ends when you have not been in a hospital, skilled nursing facility or rehabilitative facility for at least 60 days in a row. There is no limit to the number of benefit periods you can have.

CALENDAR YEAR: the period that starts with the effective date of your policy and ends on December 31st of that year. Each following calendar year shall begin 12:01 a.m. Central Time, January 1st of any year, and end 12:00 a.m. Central Time December 31st of that year.

CHARGES: the reasonable charges for items or services set by Medicare (including the limiting charge amount) or the usual and customary charge allowed amount if Medicare has not established a fee for a particular service. A charge is incurred for eligible inpatient services on the date of admission to a hospital. We treat all other charges as incurred on the date you get the service or item.

CONFINEMENT: the number of days spent as an inpatient in a hospital or skilled nursing facility.

CONTINUOUS PERIOD OF CREDITABLE COVERAGE: the period during which an individual was covered by creditable coverage, if during the period of coverage, the individual had no breaks in coverage greater than 63 days.

COPAYMENT/COINSURANCE: a specific dollar or percentage amount of allowed charges, you are required to pay as your share of the cost for a medical service or supply.

CREDITABLE COVERAGE: with respect to an individual, coverage of the individual provided under any of the following: (1) a group health plan; (2) health insurance coverage; (3) Part A or Part B of Title XVIII of the Social Security Act (Medicare); (4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; (5) Chapter 55 of Title 10 United States Code, commonly referred to as TRICARE; (6) a medical care program of the Indian Health Service or of a tribal organization; (7) a state health benefits risk pool; (8) a health plan offered under Chapter 89 of Title 5, United States Code commonly referred to as the Federal Employees Health Benefits Program; (9) a public health plan defined in federal regulation; and (10) a health benefit plan under 22 United States Code 2504(e) (Peace Corps Act).

CUSTODIAL CARE: care given to you if: (1) you do not require the technical skills of a registered nurse at all times; (2) you need services for activities of daily living including, but not limited to, dressing, bathing, eating, walking, taking medications and maintaining continence; and (3) the services you require are not likely to improve your condition. Care may still be considered custodial care as determined by Medicare, even if: (1) you are under the care of a physician; (2) the physician prescribes services to support and maintain you condition; or (3) health care services are being provided by a registered or licensed practical nurse.

EMERGENCY MEDICAL CARE: medical services directly provided by a health care provider to treat your medical emergency. A medical emergency is a condition that manifests itself by acute symptoms of sufficient severity, including sever pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in any of the following: (1) serious jeopardy to your physical or mental health;

(2) serious impairment to your bodily functions; or (3) serious dysfunction of one or more of your body organs or parts.

HOSPICE CARE: care approved by Medicare for those who are terminally ill. Hospice care typically focuses on comfort (controlling symptoms and managing pain) rather than seeking a cure.

HOSPITAL: an institution providing 24-hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons or for treatment of drug addiction or alcoholism. A professional staff of licensed physicians and surgeons must provide or supervise its services. It must provide general hospital and major surgical facilities and services. A hospital also includes a specialty hospital approved by Medicare and licensed and accepted by the appropriate state or regulatory agency to provide diagnosis and short-term treatment for patients who have specified medical conditions. It cannot be: (1) a convalescent or extended care facility within or affiliated with the hospital; (2) a nursing, rest or convalescent home, or extended care facility; (3) an institution operated mainly for care of the aged; or (4) a facility primarily providing custodial, educational or rehabilitative care.

ILLNESS: a sickness or disease, including all related conditions and recurrences, requiring medically necessary treatment, first contracted and treated on or after the effective date. We cover illnesses contracted before the effective date, subject to waiting periods and limitations. These are described later in this Policy.

INJURY: bodily harm sustained by you which is the direct result of an accident, requiring medical treatment, including suicide or attempted suicide.

MEDICALLY NECESSARY: the services or supplies provided by a hospital, physician or other provider are medically necessary when they are required to identify or treat your illness or injury and, as determined by Medicare, are: (1) consistent with the symptom or diagnosis and treatment of your illness or injury; (2) appropriate with regard to standards of acceptable medical practice; (3) not solely for the convenience of you, a physician, hospital or other provider; and (4) the most appropriate supply or level of service which can be safely provided to you.

MEDICALLY NECESSARY - MENTAL HEALTH: health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must: (1) help restore or maintain the enrollee's health; or (2) prevent deterioration of the enrollee's condition.

MEDICARE: The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

MEDICARE ELIGIBLE EXPENSES: health care expenses which are covered by Medicare Parts A and B, recognized as medically necessary and reasonable by Medicare.

MEDICARE SUPPLEMENT COVERAGE: includes Medicare supplement and Medicare Select plans but does not include coverage under Medicare Advantage plans established under Medicare Part C or Outpatient Prescription Drug plans established under Medicare Part D.

NEWLY ELIGIBLE INDIVIDUAL: an individual who is eligible for Medicare on or after January 1, 2020 because the individual: (1) attained age 65 on or after January 1, 2020; or (2) although under age 65, is entitled to or deemed eligible under Medicare Part A by reason of disability or otherwise.

PHYSICIAN: a person who: (1) received one of the following degrees in medicine from an accredited college or university: Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O.); Doctor of Dental Surgery (D.D.S.); Doctor of Dental Medicine (D.D.M.); Doctor of Podiatric Medicine (D.P.M.); Doctor of Optometry (O.D.); or Doctor of Chiropractic (D.C.); (2) medical doctor or surgeon holding a license or certificate of registration from the medical examining board in the state in which he/she is located; and (3) practices medicine within the lawful scope of his/her license.

REMITTING AGENT: the party, named by you, who will pay your premiums. You must authorize him/her to collect premiums from you and to pay us when due. He/she must notify us of any changes in your eligibility under this policy. He/she will receive our notices of premium rate change or other information about coverage. He/she is your agent; we are not liable for his/her acts or omissions.

SKILLED NURSING CARE: care furnished on a physician's orders which requires the skills of professional personnel, such as a registered or licensed practical nurse, and is provided either directly by, or under the supervision of, these personnel.

SKILLED NURSING FACILITY: an institution (or part of one) that: (1) is operated pursuant to law and approved by Medicare; (2) primarily engages in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (3) provides continuous twenty-four (24) hour a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and (4) maintains a daily medical record of each patient. Except incidentally, it is not a home or facility used primarily for rest or custodial or educational care.

USUAL AND CUSTOMARY CHARGE: the maximum amount allowed for charges submitted for services, supplies or other treatment. The charge must be comparable with charges of other providers in the geographic locality, as determined by us.

YOU/YOUR: any person who is eligible for and covered by Medicare Part A and Part B, and for whom we have accepted a proper application and the correct prepaid premium for this policy.

WE/US: UCare and/or our contracted plan administrator.

II. BENEFITS

We will pay for your care described in this Section under the terms, conditions and provisions of this policy. The services you receive must be medically necessary and meet Medicare guidelines to be covered under items A., B., or C. below. Medicare benefits will not be duplicated.

The benefits of this policy will automatically change to coincide with any changes in applicable Medicare deducible amounts and coinsurance percentage factors. When benefits change, your premium may change.

A. MEDICARE PART A SUPPLEMENTAL BENEFITS

1. Inpatient Hospital Care

   We will pay the Medical Part A hospital inpatient deductible amount per benefit period. We will also pay 100% of the Medical Part A hospital daily coinsurance amounts, and 100% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare.

2. Skilled Nursing Facility Care

   We will pay the daily copayment amount of Medicare Part A eligible expenses for the calendar year incurred for skilled nursing facility care.

3. Hospice and Respite Care

   We will pay 100% cost sharing for all Medicare Part A eligible hospice care and respite care expenses.

B. MEDICARE PART A AND B SUPPLEMENTAL BENEFITS

1. Blood

   We will pay the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under federal regulations under Medicare Parts A and B, unless replaced in accordance with federal regulations.

2. Home Health Care Services, Durable Medical Equipment, and Medical Supplies

   We will pay 100% for cost sharing for Medicare Part A or B home health care services, durable medical equipment, and medical supplies.

3. Mental Health Services

   We will pay the cost sharing of Medicare Eligible Expenses for inpatient hospital and outpatient mental health covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other provision of this policy.

C. MEDICARE PART B SUPPLEMENTAL BENEFITS

1. Outpatient Hospital and Medical Services

   We will pay for 100% of the cost sharing otherwise applicable under Medicare Part B except for the lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit and the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however this copayment shall be waived if you are admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

We cover off-label use of drugs to treat cancer if the drug is recognized for the treatment of cancer in one of the standard reference compendia or in one article in the medical literature as defined by Minnesota Statute 62Q.525.

D. FOREIGN TRAVEL EMERGENCY

1. We will pay 80% of the usual and customary charges for hospital and medical expenses and supplies incurred during travel outside of the United States as a result of a medical emergency.

III. ADDITIONAL BENEFITS

The following services are covered in addition to those provided by Medicare and are covered at 80% of usual and customary charges, unless otherwise specified.

A. COURT ORDERED MENTAL HEALTH TREATMENT

We will pay for mental health treatment ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We must be given a copy of the court order and behavioral care evaluation. We shall be financially liable for the evaluation and care included in the court-ordered individual treatment plan. This court-ordered coverage is not subject to a separate medical necessity determination.

A party or interested person, including UCare or its designee, may make a motion for modification of the court-ordered plan of care pursuant to applicable rules of procedure for modification of the court's order. Such motion may include a request for a new behavioral care evaluation.

B. TEMPOROMANDIBULAR JOINT (TMJ) AND CRANIOMANDIBULAR DISORDER (CMD)

We will pay for TMJ and CMD treatment the same as any joint in the body, if the treatment is administered or prescribed by a physician or dentist.

C. SCALP HAIR PROSTHESIS

We will pay for a scalp prosthesis worn for hair loss due to alopecia areata. Coverage is limited to one wig per calendar year.

D. VENTILATOR-DEPENDENT SERVICES

We will pay for services provided by a home care nurse or personal care assistant to a ventilator-dependent person in the person's home. We will provide coverage for up to 120 hours of services provided by a home care nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under Chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up

to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

E. RECONSTRUCTIVE SURGERY

We will pay for benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseased of the involved part.

Coverage limitations on reconstructive surgery do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician. Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient.

F. DIABETIC MANAGEMENT AND TREATMENT

We will pay benefits for (1) all physician prescribed, medical necessary and appropriate equipment and supplies used in the management and treatment of diabetes; and (2) diabetes outpatient self-management training and education, including medical nutrition therapy provided by a certified, registered, or licensed health professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage includes persons with gestational, type I or type II diabetes. Coverage is subject to the same deductible or coinsurance provisions as applicable to the hospital, medical expense, or medical equipment benefits.

G. TREATMENT OF DIAGNOSED LYME DISEASE

We will pay for treatment and diagnosed Lyme disease the same as any other medical service when not otherwise covered by Medicare.

H. PHENYLKETONURIA TREATMENT

This policy provides coverage for special dietary treatment for phenylketonuria when recommended by a physician.

I. BENEFITS FOR ALCOHOLISM AND DRUG DEPENDENCY

We will pay for treatment of outpatient and inpatient chemical dependency, mental health, and alcoholism the same as any other inpatient hospital service or outpatient treatment when not otherwise covered by Medicare. Coverage will not be more restrictive than it is for medical services.

J. OUTPATIENT MEDICAL AND SURGICAL

This policy covers outpatient medical, mental health treatment, and surgery as long as the facility is equipped to perform these services, whether or not the facility is part of a hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a hospital.

K. DIAGNOSTIC PROCEDURES FOR CANCER

This policy provides 100% coverage of usual and customary charges for routine screening procedures for cancer, including the office or facility visit. This includes mammograms, surveillance tests for ovarian cancer who are at risk, pap smears, and colorectal screening tests for men and women, when ordered or provided by a physician. Preventive mammograms include digital breast tomosynthesis for those at risk for breast cancer.

"At risk for ovarian cancer" means anyone having a family history (with one or more first or second-degree relatives with ovarian cancer); or clusters of women relatives with breast cancer; or nonpolyposis colorectal cancer; or testing positive for BRCA1 or BRCA2 mutations.

"Surveillance tests" means an annual screening using the CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination or other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

"At risk for breast cancer" means having a family history with one or more first or second-degree relatives with breast cancer; testing positive for BRCA1 or BRCA2 mutations; having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data system established by the American College of Radiology; having a previous diagnosis of breast cancer.

Routine Prostate Cancer screening is covered for men 40 years or older who are symptomatic or in a high-risk category, and for all men 50 years of age or older. Screening at a minimum consists of a prostate-specific antigen blood test and a digital rectal exam.

IV. PRE-EXISTING CONDITIONS LIMITATION

You are not covered for pre-existing conditions until after a six-month waiting period. A pre-existing condition is a disease or physical condition that was diagnosed or for which treatment was received from a physician within 90 days prior to your effective date. If the cause of the condition was earlier but the condition started after the effective date, you are covered right away. This section does not apply to you during your open enrollment period (when you turn 65 and enroll in Medicare Part B, or when you are first eligible for Medicare due to disability or end-stage kidney disease) or if you enroll during a qualified period in which the policy is guaranteed to be issued without underwriting.

V. EXCLUSIONS

The following are not covered under this policy:

A. Treatment, services or supplies Medicare does not cover, unless this policy specifically provides for them.

B. Treatment services or supplies which neither you nor a party on your behalf has a legal obligation to pay in the absence of insurance.

C. Custodial care.

D. Cosmetic surgery. We do cover such surgery if it is for repair of accidental injury or for improving the functioning of a malformed body part. We also cover, as described in this policy, reconstructive breast surgery following mastectomies, including medical emergency complications.

E. Over the counter (OTC) drugs and medicines you buy with or without a physician's prescription, except as otherwise stated.

F. Immunizations not covered by Medicare.

G. Preventive medical care services not covered by Medicare.

VI. RENEWAL TERMS, REINSTATEMENT AND MIDTERM CANCELLATION BY INSURED

A. RENEWAL TERMS

This policy is guaranteed renewable for life, subject to timely payment of premium, within the grace period. UCare shall neither cancel nor non-renew your policy for any reason other than nonpayment of premium or material misrepresentation. This policy cannot be canceled or non-renewed on the grounds of deterioration of health, or discriminate in the pricing of such coverage because of health status, claims experience, receipt of health care, medical condition, or age, or impose an exclusion of benefits based upon genetic information or a pre-existing condition.

B. REINSTATEMENT

Your policy will lapse if you do not pay the premium before the end of the grace period. We will accept payment of a renewal premium and reinstate your policy if you apply for reinstatement no later than 60 days after the due date of the premium, unless: (1) you have in the interim, left the state of Minnesota; or (2) you have applied for reinstatement on two or more prior occasions.

The reinstated policy will only cover loss due to an injury or sickness that occurs after the date of reinstatement. In all other respects, you and we have the same rights under this policy as were in effect before it lapsed. Premium accepted in connection with this provision will be used for a period for which premium has not been paid, but not for a period more than 60 days before the reinstatement.

C. MIDTERM CANCELLATION BY INSURED

This policy provides for midterm cancellation at your request and that, if you cancel this policy midterm or this policy terminates midterm because of your death, we shall issue a pro rata refund to you or to your estate.

VII. PREMIUM AND COVERAGE

A. PREMIUM RATES

Each premium after the initial period of coverage must be paid directly by calling UCare Customer Support at 1-800-221-6930 by the premium due date in order to maintain this policy in force.

For subsequent periods of coverage, your payment of the required premium by the premium due date shall maintain your coverage and keep this policy in force, subject to this policy's grace period. Your failure to pay UCare for the premium due by the due date or within the grace period, shall terminate this policy.

The same rating schedule shall apply to all of our policies with this policy form number; and the same rates shall apply to all participants in the same actuarial rating classifications, as approved by the Department of Commerce. UCare shall send you written notice of a premium rate change at least 30 days before any such change takes effect for this policy.

B. RENEWAL PERIODS

Your renewal period will be annual based on your original effective date of this policy.

C. PREMIUM DUE DATE

The premium due date is the first day of the bill frequency you select. This means that if your frequency of premium payment is quarterly, the premium due date is the first day of the quarter starting with your original effective date.

Your premium payment should be sent to us by the 20th day of the calendar month before the due date. If you choose automatic withdrawal on your application for this policy, your premium payment will be withdrawn from your bank account on the 1st day of the bill due date.

D. GRACE PERIOD

Except for the first premium, any premium not paid to us by the due date is in default. For each premium not paid when due, there is a grace period beginning with the date due during which you must pay the premium unless you have notified us in advance that you want to end this policy. The grace period is 31 days after the premium due date. This policy's coverage is in force during the grace period.

E. REQUIRED NOTICES

We are not responsible for notifying you when premiums are due for coverage provided during renewal periods under this policy if you selected automatic withdrawal from your bank account. You can designate in writing a remitting agent to pay us the premiums for this policy. If you do this, we can give any required notices to him/her, with the same effect as if we had sent them to you.

VIII. MISCELLANEOUS PROVISIONS

A. ENTIRE CONTRACT; CHANGES

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES

After two years from this policy's original effective date, no misstatements on the application will be used to void this policy or deny a claim beginning after the two-year period expires. This does not apply to fraudulent misstatements made on the application.

C. NOTICE OF CLAIM

Written notice of a claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. The notice can be given to us at P.O. Box 211522 Eagan, MN 55121 and should include information sufficient to identify the insured.

D. CLAIM FORMS

When we receive notice of claim, we will send you forms for filing proof of claim. If we fail to provide these forms within 15 days, we agree you will have met the proof of claim requirements within the time limit stated in the Proof of Claim provision.

E. PROOF OF CLAIM

You must submit proof of claim within 90 days of occurrence. If circumstances beyond your control make this time limit unreasonable, you must file the claim as soon as possible; but it cannot be later than one year and 90 days after the occurrence unless you are legally incapacitated.

F. TIME PAYMENT OF CLAIMS

All benefits payable under this policy will be payable immediately upon receipt of proper written proof of claim.

G. PAYMENT OF CLAIMS

All benefits payable under this policy will be payable to you during your lifetime, unless a valid written assignment by you to pay the medical provider is included with the claim.

Unless we receive prior written instructions from you to the contrary, any health care benefits unpaid at your death will be paid to your estate. If benefits are payable to your estate, we may pay benefits up to $1,000 to someone related to you by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

H. PHYSICAL EXAMINATIONS AND AUTOPSY

We, at our own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

I. LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

J. CONFORMITY WITH STATE STATUTES:

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

K. YOUR RELATIONSHIP WITH YOUR DOCTOR OR HOSPITAL

This contract will not alter the usual, customary relationship you have with your doctor, hospital, service or facility. We do not contract with you to choose or provide a doctor, hospital, service or facilities; nor do we assure their availability. We are not responsible to you for the acts of any health care provider or for any services or facilities. We are obligated only to provide the benefits stated in this policy.

L. PHYSICIANS AND HOSPITAL REPORTS

Physicians and hospitals must give us reports to help us determine contract benefits due to you. You hereby expressly authorize physicians, hospitals and other providers of services to release all records to us regarding services you received. This is a condition of our issuing this contract. It is also a condition of our paying benefits. All information must be furnished to the extent we deem it necessary in a particular situation and allowed by pertinent statutes.

M. RECOVERY OF EXCESS PAYMENTS

We might pay more than we owe under this policy. If so, we can recover the excess from you, the hospital, or other provider of care. We can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from us. We will only recover reimbursement of medical and medically related expenses incurred for the benefits.

N. LIMIT ON ASSIGNABILITY OF BENEFITS

This is your personal policy. You cannot assign any benefit to other than a physician, hospital, or other provider entitled to receive a specific benefit for you.

O. SEVERABILITY

If any part of this policy is ever prohibited by law, it will not apply any more. The rest of the policy will continue in force.

P. SUSPENSION OF BENEFITS AND PREMIUMS

1. Suspension Due to Entitlement to Medical Assistance

Benefits and premiums under this policy shall be suspended at your written request for a period of up to 24 months in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if you provide notice of such entitlement to UCare within 90 days after the date you become entitled to such assistance.

If such suspension occurs and you lose entitlement to such medical assistance, this policy shall be automatically reinstituted (effective as of the date of termination of such entitlement) if you provide notice of loss of such entitlement within 90 days after the date of such loss and pay the premium attributable to the policy, beginning on the date you lost entitlement to medical assistance. The reinstituted policy will otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension. The premium charged will be at least as favorable as the premium that would have applied had the coverage not been suspended.

If notice is not given or premium paid in accordance with the preceding paragraph, the suspended policy shall be canceled as of the end of the 24-month period.

There is no additional waiting period with respect to treatment of pre-existing conditions upon reinstatement.

2. Suspension While Enrolled in a Group Health Plan

Benefits and premiums under this policy shall be suspended at your written request for a period provided by federal regulation in which you have applied for and are determined to be entitled to benefits under section 226 (b) of the Social Security Act, and are covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of Social Security Act), but only if you provide proof of such entitlement to UCare within 90 days after the date you become entitled to such group health benefits.

If you lose coverage of such group health benefits, this policy shall be reinstituted (effective as of the date of loss of coverage) if you provide written notice of loss of coverage within 90 days after the date of such loss and pay the appropriate premium, beginning on the date of loss of coverage. If the suspended policy provided coverage for outpatient prescription drugs, the reinstituted policy will be without coverage for outpatient prescription drugs but will otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension.

If notice is not given or premium paid in accordance with the preceding paragraph, the suspended policy shall be canceled as of the end of the period provided by federal regulation.

If a waiting period for preexisting conditions had not been completely serviced prior to suspension of the plan, then the remainder of such waiting period will have to be completed under the reinstituted plan.

Q. EXTENSION OF BENEFITS

Termination of this policy shall be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditions on the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. The extension of benefits does not apply when the termination is based on fraud, misrepresentation, or nonpayment of premium. Receipt of Medicare Part D benefits is not considered in determining a continuous loss.

R. SUBROGATION

If we pay benefits for medical and medically related expenses to treat an illness or injury caused by the act of another party, you agree that we shall be subrogated to all of your rights to the extent of the benefits we provide under this policy. If you receive full recovery, those rights are hereby assigned to us to that extent. The assigned rights include, but are not limited to, rights against: (1) all persons or organizations, and their insurers, liable or responsible for paying for losses or damages you sustain; (2) automobile liability insurance coverage; (3) underinsured motorists insurance coverage; (4) uninsured motorists insurance coverage; (5) homeowner liability insurance coverage; (6) medical malpractice insurance coverage; (7) patient compensation funds; and (8) any applicable umbrella insurance coverage. Our subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of your costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless we are separately represented by an attorney.

If we are separately represented by an attorney, all parties may enter into an agreement regarding allocation of your costs, disbursements, and reasonable attorney fees and other expenses. If all parties cannot reach agreement on allocation, the matter shall be submitted to binding arbitration. Nothing in this section shall limit our right to recovery from another source which may otherwise exist at law. For the purposes of this section, full recovery does not include payments made by a health plan to or for the benefit of a covered person.

You shall promptly advise us in writing whenever a claim against any person and/or organization is made on your behalf and shall further provide to us such additional information as is reasonably requested by us. You agree to fully cooperate in protecting our rights against any person and/or organization. You shall not enter into a settlement or compromise arrangement with any person and/or organization without our prior written consent. Entering into any such settlement or arrangement is a breach of this contract; such a breach shall be deemed to prejudice our rights.

S. COORDINATION OF BENEFITS

This section applies when the insured has group health care coverage in addition to coverage under this policy. The insured's benefits under this policy may be reduced so that the total benefits do not exceed 100% of covered services.

If we pay more than we should have paid for medical and medically related expenses under this Coordination of Benefits rule because there is other primary coverage, we may seek reimbursement for the amount of overpayment from one or more of the following: (1) the provider we paid or for whom we have paid; (2) insurance companies; or (3) other organizations. The amount paid includes the reasonable cash value of any benefits provided in the form of services that you have received a full recovery from another source; and we have paid to account for the pro rata share of your costs, disbursements and reasonable attorney fees, and other expenses incurred in obtaining the recovery from the other source. Additionally, we will not deny overage or payment of the amount owed as a secondary payer solely on the basis of the failure of another group contract, which is responsible for primary coverage, to pay for those services.

T. QUESTIONS AND COMPLAINTS

If you have questions about your benefits or wish to file a grievance with us, we urge you to first contact Customer Support to see if we can resolve this matter to your satisfaction. You can call Customer Support using the telephone number on your identification card. Our representatives will take your information along with your proposed resolution. We will review the matter, including all information that we have available and the policy's terms, conditions, and provisions. If we agree with your proposed resolution of this matter, we will contact you by telephone or in writing by sending you a letter explaining our actions to resolve the matter. If, after receiving our response you are still unhappy with our actions, you have the right to file a written grievance with our Grievance Committee following the process explained below.

Process for issues related to enrollment, termination, premium payment or coverage of Medicare non-eligible services:

You have 3 years after you received our initial notice of denial or partial denial of your claim to file a grievance. To file a standard grievance, you should write down the concerns, issues, and comments, and mail or send by electronic facsimile (i.e. fax) the written grievance along with copies of any supporting documents to our Grievance Department at the address shown below. We do not accept grievance requests by telephone. You may fax a request if you are requesting an expedited grievance because the standard grievance process will result in serious jeopardy to your life or health, or your ability to regain maximum function. You may also qualify for an expedited grievance if in the opinion of a physician with knowledge of your medical condition the standard grievance process would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

We will acknowledge our receipt of your grievance request within 5 business days of receipt of your request. We will complete our review within 30 days of our receipt of the written complaint. If we need additional information to complete our review within the 30-day limit, we may ask you to extend the deadline by no more than 15 days. After we have completed our

review, the Grievance Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms, conditions, and/or provisions of the policy, if any, on which the decision is based, and what action, if any, has been taken by us to resolve this matter.

If your request concerns urgent services, you or your physician may request an expedited review. If your request meets our expedited review criteria, we will complete our review within 72 hours of the request. The Grievance Committee will send you its written decision by letter which will contain the specific reasons for its decision, identify the specific terms, conditions, and/or provisions of the policy, if any, on which the decision is based, and what action, if any, has been taken by us to resolve this matter. If the request does not meet our expedited review criteria, our review time will be changed to the above noted 30-day timeframe.

UCare Grievance Committee
P.O. Box 7062
Madison, Wisconsin 53707-7062
Fax Number: 608-221-6168

Medicare Covered Services Reconsideration Process

If your complaint involves a dispute relating to the payment of services covered by Medicare, you should file a Medicare appeal through Medicare. The steps you should follow for Medicare reconsiderations are explained in the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) forms, which are sent to you from Medicare. You may also contact the Social Security office at 1-800-772-1213.

At any time, you may also direct complaints about benefits to the Commissioner of Commerce at:

Minnesota Department of Commerce
Main Office, Golden Rule Building
85 7th Place East
Suite 280
Saint Paul, MN 55101
Website: https/mn.gov/commerce/about/contact/
651-539-1500 (local)
1-800-657-3602 (Greater MN only)

Mail Written Complaints to:

Minnesota Department of Commerce Attn: Consumer Services Center
85 7th Place East, Suite 280
St. Paul, MN 55101

On-line complaints:

https://mn.gov/commerce/consumers/file-a-complaint/