UniCare

UNICARE STATE INDEMNITY PLAN

PLAN BENEFITS – PLUS

Effective July 1, 2021

Summary of PLUS plan benefits

This summary shows the PLUS plan benefits for many medical and behavioral health services. For a complete and detailed description of benefits and Plan provisions, see your member handbook.

- **Deductibles** – The **PLUS deductible**, which applies to services from PLUS providers, is $500 for one person or $1,000 for a family each plan year. The separate **non-PLUS deductible** of $500 for one person – or $1,000 for a family – applies to services from non-PLUS providers.
- **Out-of-pocket cost limits** – The **PLUS out-of-pocket maximum** ($5,000 for one person and $10,000 for a family) limits your costs for services with PLUS providers. The separate **non-PLUS out-of-pocket maximum** ($5,000 and $10,000) limits your costs with non-PLUS providers.
- **Allowed amounts** – All benefits shown in this summary are limited to UniCare's allowed amounts. The allowed amount is the most that UniCare pays for a covered service.
- **Preapprovals** – Services marked with a ☎ phone symbol need to be preapproved.

Telehealth notice – There is no telehealth copay during the COVID-19 health emergency. Regulations concerning future telehealth benefits are currently under review in Massachusetts. For updates on telehealth services, requirements, and benefits, check unicaremass.com.

Benefits for medical care under PLUS

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Ambulances	PLUS deductible	PLUS deductible
Anesthesia	PLUS deductible	Non-PLUS deductible then 20% coinsurance
Bereavement counseling	PLUS deductible and 20% coinsurance *(limited to $1,500 for a family in a plan year)*	Non-PLUS deductible and 20% coinsurance *(limited to $1,500 for a family a plan year)*
Cardiac rehab programs	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Chemotherapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Chiropractic care	$20 copay and 20% coinsurance *(limited to 20 visits in a plan year)*	$20 copay, non-PLUS deductible, and 20% coinsurance (*limited to 20 visits in a plan year)*
Diabetic supplies	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Dialysis	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Doctors – office visits		
▪ Enhanced Personal Health Care PCP visits	$15 copay	*Not applicable*
▪ Other PCP visits	$20 copay	$20 copay, non-PLUS deductible, and 20% coinsurance
▪ Specialist visits	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance
▪ Telehealth visits	$15 copay	$15 copay

For self-funded plans, claims are administered by UniCare Life & Health Insurance Company.

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Doctors – other services		
▪ At an emergency room	PLUS deductible	PLUS deductible
▪ Inpatient hospital care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital care	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance
Drug screening (lab tests)	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Durable medical equipment (DME)**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Early intervention programs	No member costs	No member costs
Emergency room visits	$100 copay and PLUS deductible	$100 copay and PLUS deductible
☎ **Enteral therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Eye exams (routine)	$30/60/75 copay *(limited to one exam every 24 months)*	$60 copay and 20% coinsurance *(limited to one exam every 24 months)*
Eyeglasses and contact lenses	PLUS deductible and 20% coinsurance *(limited to the first lenses within six months after eye injury or cataract surgery)*	PLUS deductible and 20% coinsurance *(limited to the first lenses within six months after eye injury or cataract surgery)*
Family planning services	No member costs	No member costs
Fitness club reimbursement	Reimbursed up to $100 for the family in a plan year	Reimbursed up to $100 for the family in a plan year
Hearing aids		
▪ Age 21 and under	No member costs *(limited to $2,000 for each impaired ear every 24 months)*	No member costs *(limited to $2,000 for each impaired ear every 24 months)*
▪ Age 22 and over	No member costs for first $500, then 20% coinsurance of the next $1,500 *(up to a total benefit limit of $1,700 every 24 months)*	No member costs for first $500, then 20% coinsurance of the next $1,500 *(up to a total benefit limit of $1,700 every 24 months)*
Hearing exams	$15/20/30/60/75 copay	$20/60 copay, non-PLUS deductible, and 20% coinsurance
☎ **High-tech imaging (e.g., MRIs, CT and PET scans)**		
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital and non-hospital-owned locations	$100 daily copay and PLUS deductible	$100 daily copay, non-PLUS deductible, and 20% coinsurance
☎ **Home health care**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Home infusion therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Hospice care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Immunizations (vaccines)	No member costs *(you may have costs for an office visit)*	No member costs *(you may have costs for an office visit)*
☎ **Inpatient services**		
▪ At a hospital or rehab facility (semi-private room)	$275/500/1,500 quarterly copay and PLUS deductible	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275/500/1,500 quarterly copay and PLUS deductible ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **First 90 days:** $500 quarterly copay, non-PLUS deductible, and 20% coinsurance ▪ **After 90 days:** 20% coinsurance, and the dollar difference between the semi-private room rate and the private room rate

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
☎ **Inpatient services** *(continued)* ▪ Neonatal ICU	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $275/500/1,500 quarterly copay and PLUS deductible	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $500 quarterly copay, non-PLUS deductible, and 20% coinsurance
Lab services	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Occupational therapy**	$20 copay	$20 copay and non-PLUS deductible
Office visits ▪ Enhanced Personal Health Care PCP visits	$15 copay	*Not applicable*
▪ Other PCP visits	$20 copay	$20 copay, non-PLUS deductible, and 20% coinsurance
▪ Specialist visits	$30/60/75 copay	$60 copay, non-PLUS deductible, and 20% coinsurance
▪ Telehealth visits	$15 copay	$15 copay
Oxygen	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Personal Emergency Response Systems (PERS) ▪ Installation	PLUS deductible and 20% coinsurance *(limited to $50 in a plan year)*	PLUS deductible and 20% coinsurance *(limited to $50 in a plan year)*
▪ Rental	PLUS deductible and 20% coinsurance *(limited to $40 a month)*	PLUS deductible and 20% coinsurance *(limited to $40 a month)*
☎ **Physical therapy**	$20 copay	$20 copay and non-PLUS deductible
Prescription drugs	▪ From a network pharmacy (30-day supply): $10/30/65 copay ▪ By mail order (90-day supply): $25/75/165 *Benefits are administered by Express Scripts. Call 855-283-7679 for information.*	
Preventive care	No member costs	No member costs
☎ **Private duty nursing in a home setting**	PLUS deductible and 20% coinsurance *(limited to $8,000 in a plan year)*	Non-PLUS deductible and 20% coinsurance *(limited to $8,000 in a plan year)*
Prosthetics and orthotics ▪ Breast prosthetics	PLUS deductible	Non-PLUS deductible
▪ Other prosthetics and orthotics	PLUS deductible and 20% coinsurance	Non-PLUS deductible and 20% coinsurance
☎ **Radiation therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Radiology (e.g., X-rays) ▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital and non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Retail health clinic visits	$20 copay	$20 copay
☎ **Skilled nursing and long-term care facilities**	PLUS deductible and 20% coinsurance *(limited to 45 days in a plan year)*	PLUS deductible and 20% coinsurance *(limited to 45 days in a plan year)*
☎ **Sleep studies**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Speech therapy** ▪ With an autism diagnosis	No member costs	Non-PLUS deductible and 20% coinsurance
▪ All other speech therapy	No member costs *(limited to 20 visits in a plan year)*	Non-PLUS deductible and 20% coinsurance *(limited to 20 visits in a plan year)*

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
☎ **Surgery**		
▪ Inpatient hospital	PLUS deductible *(you also have an inpatient copay; see "Inpatient services")*	Non-PLUS deductible and 20% coinsurance *(you also have an inpatient copay; see "Inpatient services")*
▪ Outpatient hospital	$110/110/250 quarterly copay and PLUS deductible	$110 quarterly copay, non-PLUS deductible, and 20% coinsurance
▪ Non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Telehealth visits	$15 copay	$15 copay
Tobacco cessation counseling	No member costs *(limited to 300 minutes in a plan year)*	No member costs *(limited to 300 minutes in a plan year)*
☎ **Transplants**		
▪ At a Quality Center or Designated Hospital for transplants	$275/500/1,500 quarterly copay and PLUS deductible	$275/500/1,500 quarterly copay and PLUS deductible
▪ At other hospitals	$275/500/1,500 quarterly copay, PLUS deductible, and 20% coinsurance	$500 quarterly copay, non-PLUS deductible, and 20% coinsurance
Urgent care center visits	$20 copay	$20 copay
Wigs (after cancer treatment)	20% coinsurance	20% coinsurance

Benefits for behavioral health care under PLUS

Service	Your member costs with PLUS providers	Your member costs with non-PLUS providers
Emergency service programs	No member costs	No member costs
☎ **Inpatient services**	$200 quarterly copay	$200 quarterly copay, non-PLUS deductible, and 20% coinsurance
Medication-assisted treatment	No member costs	No member costs
Medication management	$15 copay	$20 copay and non-PLUS deductible
☎ **Office services**	$15 copay	$20 copay and non-PLUS deductible
☎ **Outpatient services**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Substance use disorder assessment / referral	No member costs	No member costs
Telehealth visits	▪ Visits 1-3: No member costs ▪ After 3 visits: $15 copay	$15 copay
Therapy		
▪ Individual therapy	$15 copay	$20 copay and non-PLUS deductible
▪ Family therapy	$15 copay	$20 copay and non-PLUS deductible
▪ Group therapy	$15 copay	$20 copay and non-PLUS deductible