SERIES 1

UNICARE STATE INDEMNITY PLAN BASIC

Member Handbook for Active Employees and Non-Medicare Retirees

Effective July 1, 2016

UNICARE®

Commonwealth of Massachusetts
Group Insurance Commission

UNICARE STATE INDEMNITY PLAN/BASIC MEMBER HANDBOOK

For active employees and non-Medicare retirees

Effective July 1, 2016

Disclosure when Plan Meets Minimum Standards

*This health plan **meets the Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see additional information below.*

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2008, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 877-MA-ENROLL or visit the Connector website (mahealthconnector.org).

This health plan meets the **Minimum Creditable Coverage standards** that became effective July 1, 2008 as part of the Massachusetts Health Care Reform Law. If you are covered under this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2016. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at mass.gov/doi.

Interpreting and Translating Services

If you need a language interpreter when you call UniCare Customer Service, a customer service representative will access a language line and connect you with an interpreter who will translate your conversation with the representative.

If you are deaf or hard of hearing and have a telecommunications device for the deaf (TDD) machine, you can contact UniCare by calling our TDD line at 800-322-9161 or 978-474-5163.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Who to Contact

For questions about your medical plan	
UniCare State Indemnity Plan Customer Service Center P.O. Box 9016 Andover, MA 01810-0916 800-442-9300 (toll free) TDD[1]: 800-322-9161 contact.us@anthem.com unicarestateplan.com	▪ What your benefits are for a particular medical service or procedure ▪ The status of (or a question about) a medical claim ▪ How to find a doctor, hospital or other medical provider ▪ Information that appears in Part 1, the "Your Medical Plan" section of this handbook
For questions about your prescription drug plan	
CVS Caremark 877-876-7214 (toll free) TDD[1]: 800-238-0756 caremark.com	▪ What your benefit is for a prescription drug ▪ The status of (or a question about) a prescription drug claim ▪ Where to get prescriptions filled ▪ Which drugs are covered ▪ Information that appears in Part 2, the "Prescription Drug Plan" section of this handbook
For questions about your behavioral health plan	
Beacon Health Options 855-750-8980 (toll free) TDD[1]: 866-727-9441 beaconhealthoptions.com/gic	▪ What your benefits are for mental health services ▪ What your benefits are for substance use disorder services ▪ What your benefits are for the Enrollee Assistance Program (EAP) ▪ The status of (or a question about) a mental health, substance use disorder, or EAP claim ▪ Information that appears in Part 3, the "Behavioral Health Plan" section of this handbook
For general health questions after hours (not about plan benefits or coverage)	
24/7 NurseLine 800-424-8814 (toll free) Plan code: 1002	▪ How to prepare for an upcoming medical procedure ▪ What side effects are possible from your medication ▪ Whether to go to an urgent care center or call your doctor ▪ See page 99 for more information about the 24/7 NurseLine

For other questions, such as questions about premiums or participation in any Group Insurance Commission (GIC) programs, please see your GIC coordinator or contact the GIC.

1 Telecommunications Device for the Deaf

Table of Contents

Disclosure when Plan Meets Minimum Standards 2

Interpreting and Translating Services 2

Who to Contact 3

Part 1: Your Medical Plan..... 11

Describes the benefits for medical services, treatment and supplies. These benefits are administered by the UniCare State Indemnity Plan.

1: Getting started with the Basic Plan 12
Introducing your medical plan 12
Prescription drugs and behavioral health 12
Do you have benefits under another health plan? 13
Using this handbook 13
What the handbook symbols mean..... 13
About your ID cards 13
When you must provide notice about your care..... 14
List of notification requirements 16

2: What to know about costs..... 20
What member costs are 20
How member costs work..... 20
About your deductible 21
About copays..... 22
About coinsurance..... 25
Limits to your member costs 25
About allowed amounts..... 25
About balance billing 26
About preferred vendors..... 27

3: Find out what's covered..... 28
Summary of benefits 28
Ambulance services..... 33
Anesthesia 33
Autism spectrum disorders..... 33
Behavioral health services..... 33
Cardiac rehabilitation programs 34
Chemotherapy 34

Chiropractic care 34
Circumcision 35
Cleft lip and cleft palate for children under 18 35
Clinical trials (clinical research studies) 35
Dental services 37
Diabetes care 37
Diabetes supplies 38
Dialysis 39
Doctor and other health care provider services 39
Durable medical equipment (DME) 40
Early intervention programs for children 41
Emergency room 41
Enteral therapy 42
Eye care 42
Eyeglasses and contact lenses 43
Family planning 43
Fitness club reimbursement 44
Foot care (routine) 44
Gynecology exams 45
Hearing aids 45
Hearing exams 45
Home health care 46
Home infusion therapy 47
Hospice care 47
Infertility treatment 48
Inpatient care at hospitals 50
Inpatient care at other facilities 52
Laboratory services 52
Maternity services 53
Medical clinics (non-hospital-owned) 53
Medical services (not otherwise specified) 53
Nutritional counseling 54
Occupational therapy 54
Outpatient hospital services 54
Oxygen 55
Palliative care 55
Personal Emergency Response Systems (PERS) 55
Physical therapy (manipulative therapy) 56
Prescription drugs 56
Preventive care 56
Private duty nursing 57
Prosthetics and orthotics 57
Radiation therapy 58
Radiology and imaging services 58

Sleep studies ... 59
Speech therapy ... 59
Surgery ... 60
Tobacco cessation counseling ... 61
Transplants ... 62
Travel clinics ... 63
Wigs ... 63
Schedule of preventive care services ... 64

4: Coverage that is excluded or limited ... 68

5: About your plan and coverage ... 75
How to use your plan wisely ... 75
Types of health care providers ... 76
How to find providers ... 78
About physician tiering ... 78
How UniCare reimburses providers ... 80
How to submit a claim ... 80
Deadlines for filing claims ... 80
Checking your claims for billing accuracy ... 81
About claim reviews ... 82
Deadlines on bringing legal action ... 82
Right of reimbursement ... 82
About your privacy rights ... 82
About your appeal rights ... 83
How medical services get reviewed ... 83
Getting support for serious medical issues ... 84

6: About enrollment and membership ... 85
Free or low-cost health coverage for children and families ... 85
Application for coverage ... 85
When coverage begins ... 85
When coverage ends for enrollees ... 86
When coverage ends for dependents ... 86
Duplicate coverage ... 86
Special enrollment condition ... 86
Continuing coverage upon termination of employment ... 86
Group health continuation coverage under COBRA ... 88
Conversion to non-group health coverage ... 92
Coordination of Benefits (COB) ... 93

7: How to get more information ... 96
Who to contact (and for what) ... 96
Contacting the UniCare Customer Service Center ... 97
Using the unicarestateplan.com website ... 98

Using the 24/7 NurseLine 99
How to ask for a claim review 100
How to check on your claims 100
How to ask to have medical information released 100

8: Definitions 101

Part 2: Prescription Drug Plan 107

Describes the benefits for prescription drugs. These benefits are administered by CVS Caremark.

About Your Plan 108
Copayments 109
Out-of-Pocket Limit 110
How to Use the Plan 110
Claim Forms 113
Other Plan Provisions 113
Exclusions 117
Definitions 117
Member Appeals 119
Health and Prescription Information 121

Part 3: Behavioral Health Plan 123

Describes the benefits for mental health, substance use disorder and the Enrollee Assistance Program. These benefits are administered by Beacon Health Options.

Part I – How to Use this Plan 124
How to Contact Beacon Health Options 124
How to Get Optimal Benefits 124
Referral/Prior Authorization for EAP and Non-Routine Services 125
Emergency Care 125
Urgent Care 125
Routine Care 126
Confidentiality 126
Coordination of Benefits 126

Part II – Benefits 127
Benefits Explained 127
What This Plan Pays: Summary of Covered Services 131
Covered Services 134
Enrollee Assistance Program (EAP) 137
Case Management 138
What's Not Covered – Exclusions 139

Part III – Definitions, Appeals, Complaints and Grievances 142
Definitions of Beacon Health Options Behavioral Health Terms 142
Filing Claims 144
Complaints 144
Appeals 145

Appendices 149

Appendix A: GIC Notices 150
Notice of Group Insurance Commission (GIC) Privacy Practices 150
Important Notice from the GIC about Your Prescription Drug Coverage and Medicare 152
The Uniformed Services Employment and Reemployment Rights Act (USERRA) 154
Overview of Health Insurance Marketplaces 155

Appendix B: Forms 157
Fitness Club Reimbursement Form 158
Bill Checker Program Form 159

Appendix C: Federal and State Mandates 160
Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP) 160
Coverage for Reconstructive Breast Surgery 163
Minimum Maternity Confinement Benefits 163

Appendix D: Your Right to Appeal 164
Notice of Adverse Benefit Determination 164
Appeals 165
How Your Appeal Will Be Decided 166
Notification of the Outcome of the Appeal 166
Appeal Denial 166
External Review 167
Requirement to File an Appeal before Filing a Lawsuit 168

Index 169

List of Tables

Table 1. Notification Requirements 16
Table 2. Deductible Amounts 21
Table 3. Copays for Office Visits and Other Medical Services 24
Table 4. Out-of-Pocket Limit 25
Table 5. Summary of Covered Services 28
Table 6. Preventive Care Schedule 64
Table 7. Copayments for Prescription Drugs 109
Table 8. Out-of-Pocket Limit 110
Table 9. Claims Reimbursement 113
Table 10. Current Examples of Drugs Requiring Prior Authorization for Specific Conditions 115
Table 11. Current Examples of Top Drug Classes that May Require Prior Authorization for Medical Necessity 115
Table 12. Mental Health, Substance Use Disorder, and EAP Benefits 129
Table 13. Summary of Covered Services 131

PART 1:
YOUR MEDICAL PLAN

Description of Benefits

For questions about any of the information in Part 1 of this handbook, please contact UniCare at 800-442-9300.

Administered by

1: Getting started with the Basic Plan

This handbook is a guide to benefits for you and your dependents covered under UniCare State Indemnity Plan/Basic (the Basic plan). These benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for state, participating municipalities and other governmental entities' employees and retirees. This Plan is funded by the Commonwealth of Massachusetts and administered by UniCare.

UniCare provides administrative services for UniCare State Indemnity Plan/Basic – including claims processing, customer service, pre-service reviews and case management – at its Customer Service Center in Andover, Massachusetts. UniCare is not the fiduciary or the insurer of UniCare State Indemnity Plan/Basic.

Read this handbook carefully to fully understand your benefits. If you have questions about any of your benefits, see the contact information on page 3.

Introducing your medical plan

UniCare State Indemnity Plan/Basic provides comprehensive coverage anywhere in the world for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. You can get services from any provider, anywhere in the world. Keep in mind, however, that benefits differ depending on the service and the provider, and that not all services are covered by the Plan.

Part 1 of this handbook (pages 11-105) describes your coverage for medical services, and provides information about two different medical plan designs:

1. **UniCare State Indemnity Plan/Basic *with* CIC (Comprehensive Insurance Coverage)** is a comprehensive plan that provides benefits for most services at 100% coverage after the applicable copay and/or deductible.
2. **UniCare State Indemnity Plan/Basic *without* CIC** is a less comprehensive plan that provides benefits for many services at 80% coverage after the applicable copay and/or deductible.

Prescription drugs and behavioral health

- ❑ Your **prescription drug benefits** are administered by **CVS Caremark**. These benefits are described in Part 2 of this handbook (pages 107-121).
- ❑ Your **behavioral health benefits** are administered by **Beacon Health Options**. These benefits include coverage for mental health, substance use disorder and the Enrollee Assistance Program (EAP). They are described in Part 3 of this handbook (pages 123-147).

Do you have benefits under another health plan?

If you or a family member is covered under another health plan, you must let UniCare know about the other plan. When you received your member materials (including this handbook), you should have filled out and returned the *Other Health Insurance* form. If you have other health coverage and haven't yet filled out this form, please call UniCare Customer Service at 800-442-9300 to request one.

To learn more about how UniCare coordinates benefits with other health plans, turn to "Coordination of Benefits (COB)" on page 93.

Using this handbook

Throughout this handbook, UniCare State Indemnity Plan/Basic is referred to by its full name, or as the UniCare State Indemnity Plan, the Basic plan, or the Plan. The Group Insurance Commission is referred to either by its full name or as the GIC. In addition, the term "you" used in this handbook also includes your covered dependents.

What the handbook symbols mean

Important information – Pay particular attention to this information because it may have an impact on your benefits.

No coverage, limited coverage, or benefit restriction – There is a limitation, exclusion or some other restriction on this benefit. A full list of benefit restrictions appears in Chapter 4.

Notify UniCare – You (or someone acting for you) must tell UniCare if you are having this service or procedure. If you don't do so, your benefits may be reduced by up to $500. See "When you must provide notice about your care" on page 14 for details about this requirement.

Notify AIM – Your provider must notify **AIM Specialty Health℠** if you are going to have this service or procedure. If AIM isn't notified, your benefits may be reduced by up to $500. See "When you must provide notice about your care" on page 14 for details about this requirement.

Use UniCare preferred vendors – To get the best benefit, use a UniCare preferred vendor for this service or product. See page 27 to learn more.

Check the website – Information about this topic can be found at unicarestateplan.com.

About your ID cards

When you enroll in the Plan, you will get either one or two UniCare ID cards, depending on where you live. These cards have useful information about your benefits, as well as important telephone numbers you and your health care providers may need.

If you lose a UniCare ID card or need additional cards, you can order them from unicarestateplan.com. Or, call UniCare Customer Service at 800-442-9300 for help.

Prescription drug cards – CVS Caremark will send your prescription drug cards in a separate mailing. Call CVS at 877-876-7214 if you have any questions about your prescription drug card.

If you live in Massachusetts

Massachusetts residents get a blue UniCare ID card. Use this card any time you get medical care, both in Massachusetts and when you travel.

If you live outside of Massachusetts

To get the best coverage, members who live outside of Massachusetts should always use network providers in their home states. Although your care is covered at other providers, non-network providers may balance bill you for charges above what the Plan pays. See page 26 to find out more about balance billing.

Members who live outside of Massachusetts get two cards when they enroll in the Plan: a blue UniCare ID card and a green network card.

- ❑ **When you get care in your home state** – Use your green network card when you get medical care from network providers in your home state.
- ❑ **When you travel** – Use your blue UniCare ID card if you need urgent care when traveling outside your home state.
- ❑ **In Massachusetts** – Use your blue UniCare ID card to get medical care in Massachusetts.

When you must provide notice about your care

Under some circumstances, you or your provider must tell UniCare about certain medical services you get. These services are reviewed to make sure they are eligible for benefits. This review process reduces your risk of having to pay for services that aren't covered. To learn more about how services are reviewed, see page 83.

You must provide notice if:

- ❑ You will be or have been admitted to the hospital, or
- ❑ You are scheduled to have a service that requires pre-service review

Table 1 on pages 16-19 lists all the services that require notice. For each listed service, the table also tells you:

- ❑ How far in advance you must give notice (for example, one business day or seven calendar days before the service takes place)
- ❑ Who must be notified (either UniCare Customer Service or AIM Specialty Health)

Who to notify

Some services are reviewed by UniCare at its Customer Service Center. Other services are reviewed by **AIM Specialty Health**SM, a UniCare-affiliated company that provides support for the review process. Services reviewed by AIM are marked with a ▶ **triangle**.

Notifying the UniCare Customer Service Center

When you need to provide notice of a service that UniCare must review, you (or someone acting for you) can contact UniCare Customer Service at:

800-442-9300 (toll free)
TDD: 800-322-9161

Information you must provide

Be sure to have the following information when you contact UniCare Customer Service:

- ❑ **Who is having this service** – The name, birth date, and contact information for the person who is having the service. This may be the Plan enrollee (subscriber) or the enrollee's dependent.
- ❑ **Who the UniCare enrollee is** – The name and UniCare ID number of the Plan enrollee.
- ❑ **What this service is** – The service or procedure (from the list in Table 1), the associated diagnosis, and the scheduled date of the service.
- ❑ **Where this service is to take place** – The name and contact information of the facility where the service will occur.
- ❑ **Who the ordering doctor is** – The name and contact information of the medical provider who ordered the service.

Notifying AIM Specialty Health

Services that are reviewed by AIM are marked with a ▶ **triangle**. Your provider must contact AIM at:

AIM Specialty Health
866-766-0247 (toll free)
aimspecialtyhealth.com/goweb
aimspecialtyhealth.com/gowebsleep

If you're not sure whether notice is required

If you're not sure whether you must provide notice, or if you don't know the medical term for the service, ask your provider to see if the service is listed in Table 1. Or, you or your provider can contact UniCare at 800-442-9300 to find out.

☞ Important points to remember

- ❑ **If you don't provide notice within the required amount of time, your benefits may be reduced by up to $500.**
- ❑ **Submitting a claim for service is not enough to meet these notification requirements. UniCare (or AIM) must be notified before the service takes place.**
- ❑ **You don't need to provide notice if you are outside the continental United States (all states but Alaska and Hawaii).**
- ❑ **The telephone ☎ marks services you need to notify UniCare about.**
- ❑ **The triangle ▶ marks services that your provider needs to tell AIM about.**

List of notification requirements

☎ For services marked with a telephone, you (or your provider) must notify UniCare Customer Service within the amount of time indicated.

▶ For services marked with a triangle, your provider must notify AIM Specialty Health within the amount of time indicated.

Note that some of the listed services may be performed in a doctor's office.

Table 1. Notification Requirements

▶ ✓ **BPAP and CPAP equipment**	**At least 1 business day before ordering**
☎ **Breast cancer genetic testing**	**At least 7 days before testing**
Testing for the breast cancer susceptibility gene (BRCA)	
☎ **Chiropractic care or manipulative therapy for children under 13**	**At least 1 business day before services start**
Services must be provided by a chiropractor or by a medical or osteopathic physician	
☎ **Cleft palate and cleft lip treatment**	**At least 7 days before services start**
Treatment or services to correct a birth defect where there is a split in the lip and roof of the mouth	
☎ **Colonography (virtual colonoscopy)**	**At least 7 days before services start**
CT scan of the colon and rectum to detect colorectal polyps and colorectal cancer	
☎ ✓ **Durable medical equipment (DME)**	**At least 1 business day before ordering equipment**
You must notify UniCare if the purchase price is more than $500, or if the expected rental costs will be more than $500. You don't need to provide notice for oxygen or oxygen equipment.	
▶ **Echocardiography**	**At least 7 days before the procedure**
Resting transthoracic echocardiography	Standard echocardiogram (also known as a transthoracic echocardiogram (TTE)) or cardiac ultrasound
Stress echocardiography	Cardiac stress test done with heart stimulation, either by exercise or with intravenous pharmacological (drug) stimulation
Transesophageal echocardiography	Specialized test that passes a probe with an ultrasound transducer into the esophagus
☎ ✓ **Enteral therapy**	**At least 1 business day before services start**
Prescribed nutrition administered through a tube inserted into the stomach or intestines	
☎ **Gender reassignment surgery**	**At least 21 days before services start**
Surgical procedures that alter the appearance and function of a transgender person's existing sexual characteristics to resemble those of the person's identified gender	

Table 1. Notification Requirements *(continued)*

▶ High-tech imaging	At least 7 days before the procedure
CT scan	Special computerized X-ray of structures within the body
CTA scan	Special computerized X-ray of blood vessels within the body
Echocardiology	Imaging of the heart
MRI	Imaging study of soft tissues in the body
MRA scan	Imaging study of blood vessels within the body
Nuclear cardiology	Studies using radioactive substances and non-invasive techniques to assess heart blood flow and heart muscle function
PET scan	Specialized three-dimensional imaging of parts of the body
SPECT scan	Specialized three-dimensional imaging of various tissues and organs

☎ Home health care	At least 1 business day before services start
Services must be provided by one of the following: ▪ Private duty nurse ▪ ✓ Home health agency ▪ ✓ Visiting nurse association	

☎ Hyperbaric oxygen therapy	At least 7 days before services start
Administration of pure oxygen at higher than atmospheric pressure	

☎ Inpatient hospital services	
Emergency admission	Notice required within 24 hours (or next business day)
Maternity admission	Notice required within 24 hours (or next business day)
Non-emergency admission	Notice required at least 7 calendar days before admission for elective inpatient treatment

☎ Occupational therapy	At least 1 business day before services start
☎ Physical therapy	At least 1 business day before services start
☎ Private duty nursing	At least 1 business day before services start
Services must be provided by one of the following: ▪ Private duty nurse ▪ ✓ Home health agency ▪ ✓ Visiting nurse association	

Table 1. Notification Requirements *(continued)*

▶ Radiation therapy	At least 7 days before services start
Brachytherapy	A form of radiation therapy where a radiation source is placed inside or next to the area requiring treatment
CyberKnife	Robotic radiosurgery system used for treating tumors and other medical conditions
IMRT (intensity-modulated radiation therapy)	A type of radiation that shapes the radiation beams to closely approximate the shape of the tumor
Proton beam	A type of particle therapy using a beam of protons to irradiate diseased tissue
Traditional radiation	The use of ionizing radiation to control or kill malignant cells

▶ Sleep studies (including polysomnography) — **At least 7 days before the study starts**

Sleep study that monitors you as you sleep, either in a facility or a home setting

▶ Specialty drugs — **At least 7 days before administration**

- Ado-trastuzumab emtansine *(Kadcyla)*
- Alemtuzumab *(Lemtrada)*†
- Belatacept *(Nulojix)*†
- Bevacizumab for oncolytic use *(Avastin)*
- Botulinum toxin *(e.g., Botox)*†
- Brentuximab vedotin *(Adcetris)*
- Carfilzomib *(Kyprolis)*
- Cetuximab *(Erbitux)*
- Denosumab *(Xgeva)*†
- Dexamethasone *(Ozurdex)*
- Epoprostenol *(Veletri)*†
- Eribulin mesylate *(Halaven)*
- Fibrinogen *(RiaSTAP)*
- Fluocinolone acetonide *(Retisert)*
- Hyaluronic acid *(e.g., Hyalgan, Synvisc)*
- Injection treatment for retinal vascular conditions *(e.g., Lucentis, Macugen)*
- Ipilimumab *(Yervoy)*
- Nivolumab *(Opdivo)*
- Panitumumab *(Vectibix)*
- Pembrolizumab *(Keytruda)*
- Pertuzumab *(Perjeta)*
- Plerixafor *(Mozobil)*
- Rituximab *(Rituxan)*†
- Taliglucerase alfa *(Elelyso)*
- Trastuzumab *(Herceptin)*
- Ziconotide *(Prialt)*

† If you will be getting this drug as a hospital outpatient, there is an additional review to determine if the site of service is eligible for benefits. However, this secondary review isn't needed if the drug is for oncological use.

Additional specialty drugs (non-oncology) require review and are dispensed by the prescription drug plan (Part 2 of this handbook). Also see restriction #22 on page 69.

Important! This list of specialty drugs is subject to change during the year. Check unicarestateplan.com for the most current list, or call UniCare Customer Service at 800-442-9300 to ask for an updated list.

☎ Surgery	At least 7 days before surgery
Back surgery	Including, but not limited to, procedures listed here, as well as any other spinal instrumentation not otherwise specified
Cardioverter-defibrillator implantation	Surgical implantation of a device to continuously monitor the heart rhythm to detect and correct abnormal heart rhythms
Cervical fusion	Surgical joining of two or more vertebrae at the cervical levels of the spine; may also be referred to as cervical spine fusion or spinal arthrodesis

Table 1. Notification Requirements *(continued)*

☎ **Surgery** (continued)	**At least 7 days before surgery**
Discectomy – lumbosacral spine (open, percutaneous and endoscopic, and other minimally invasive procedures to treat back pain)	Procedures on the spine using small incisions through the skin and probes, endoscopes or catheters to perform procedures
Knee arthroscopy	Surgical procedure in which the knee joint is viewed using a small camera in order to get a clear view of the inside of the knee
Knee meniscal transplant	Transplant of special cartilage into the knee to treat certain types of knee pain and problems
Laminectomy / laminotomy of the lumbosacral spine	Any surgical procedure removing portions of the vertebra to relieve pressure on the spinal cord or nerve roots in the lower back
Sinus surgery (including endoscopy)	Any procedure by any method that opens, removes or treats the nasal sinuses, including the use of an endoscope
Spinal cord stimulator and neuromodulator implantation	Implantation of a device that delivers electrical current directly to specific areas of the spinal cord with implanted electrodes, to treat pain or urinary incontinence
Spinal fusion of the lumbosacral spine	Surgical procedures in which two or more of the vertebrae in the lower back are fused together
Spinal instrumentation of the lumbosacral spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
Upper gastrointestinal endoscopy	Examination of the upper gastrointestinal (UGI) area (that is, the esophagus, stomach and duodenum) through a flexible telescopic tube (endoscope) for diagnosis and/or treatment
Vertebroplasty	Injection of material into the center of a collapsed spinal vertebra to repair fractures
☎ **Transplants**	**At least 21 days before services start**
You don't need to provide notice for cornea transplants.	
☎ **Varicose vein treatment (including sclerotherapy)**	**At least 7 days before treatment**
Treatment or services for veins in the legs that have become twisted or enlarged	

2: What to know about costs

What member costs are

Member costs are the costs for medical care that are your responsibility to pay (they are sometimes called **out-of-pocket costs**). There are three different types of member costs. These costs are separate and unrelated; they apply in different situations and are for different services. The three types of member costs which are described in this chapter are:

- **Deductible** – This is a fixed amount you pay toward medical services each year before the Plan starts paying benefits for those services. Once you have paid the full amount, you won't owe any more deductible until the start of the following plan year. See page 21 for details about the deductible.
- **Copays (copayments)** – A copay is a set amount you pay when you get certain medical services. For example, you pay a copay when you see your doctor for a sore throat, or when you get outpatient surgery at a hospital. The dollar amount of your copay varies based on the service you're getting and the provider you're using. See pages 22-24 for details about copays.
- **Coinsurance** – This is your share of the cost of a covered service when the service isn't covered at 100%. For example, if the Plan pays 80% of the allowed amount for a service, you are responsible for paying the other 20%. See page 25.

There are caps that limit how much you could pay each plan year for these member costs. These caps, called **out-of-pocket limits**, limit how much you'll spend each plan year on the combination of deductible, copays and coinsurance. See page 25 for details about the out-of-pocket limits.

What is a plan year? The plan year starts on July 1 each year and ends the following June 30th.

How member costs work

When UniCare gets a claim for medical services that you or someone in your family had, we subtract any member costs you owe from the amount we pay to that provider. If there is a copay, that gets subtracted first. Then, the deductible – if it applies – is subtracted, and finally the coinsurance, if any. If you owe any member costs, we'll send you an *Explanation of Benefits* (EOB) statement that shows you how the claim has been paid and what you owe to the provider.

After receiving payment from UniCare, your provider will send you a bill for the amount of your member costs; that is, the amount UniCare subtracted from the bill before paying the provider.

Note that we process your claims as they arrive at UniCare. This means that your claims may not be paid in the same order in which you got the medical services.

About your deductible

The **deductible** is a set amount you pay toward medical services each plan year before UniCare starts paying benefits for those services. Your deductible starts on July 1 each year. Depending on how much a claim is for, it may take more than one claim before your deductible is *satisfied* (fully paid).

The deductible applies to many, but not all, covered services. For example, you owe your deductible for inpatient hospital care, but not for occupational therapy. Inpatient hospital care is *subject to the deductible*, but occupational therapy is not. Chapter 3 shows which services are subject to the deductible.

You have one deductible that applies to both your medical claims and any claims you have for out-of-network behavioral health (mental health/substance use disorder) services. The deductible amounts are shown in Table 2.

Table 2. Deductible Amounts

For an individual	**$300 for one person**
For a family	**$900 for the entire family** For any one person in the family, the deductible is capped at $300

Deductible for an individual

The $300 individual deductible is the amount you must pay each plan year before UniCare starts to pay for many medical services and out-of-network behavioral health services.

Example – You have coverage in the Basic plan with CIC. In July, you get behavioral health services from an out-of-network provider and pay $200 toward your deductible. You now have $100 of your deductible left. In August, you go to a provider for medical care. If this second bill is *more* than $100, you pay $100 – the rest of your deductible – and the Plan pays the covered amount of the remaining charges. However, if this second bill is *less* than $100, then the rest of your deductible will be taken the next time you go to a medical or out-of-network behavioral health provider.

Deductible for a family

The $900 family deductible is the most your family could pay each plan year before UniCare starts to pay for many medical services or out-of-network behavioral health services. The most you'll owe for any one family member is $300, until the family as a whole reaches the $900 limit.

Example – You, your spouse and your two children have family coverage in the Basic plan with CIC. In July, you and your two children go to providers for medical care. All three of you pay $250 deductibles, for a total of $750 toward the family deductible. In August, your spouse goes to an out-of-network behavioral health provider and pays $150 deductible. Even though no single family member has reached the $300 cap, the family deductible of $900 has been met. Therefore, no additional deductible will apply to your family for the rest of the plan year.

About copays

A **copay** (**copayment**) is a set amount you pay when you get certain medical services. For example, you pay a copay when you see your doctor for a sore throat, or when you get outpatient surgery at a hospital. The dollar amount of your copay depends on what service you're getting and what kind of provider you're seeing. See Table 3 on page 24 for a list of services and copay amounts.

Copays can work in two ways:

- **Per-occurrence copays** – These are copays you pay every time you have a particular service. Doctor visits, high-tech imaging, physical therapy, occupational therapy and emergency room visits are all per-occurrence copays.
- **Quarterly copays** – You pay quarterly copays only once each calendar quarter, no matter how many times you get that service during the quarter. There are quarterly copays for inpatient hospital care and outpatient surgery at a hospital.

What is a calendar quarter? The calendar quarters are July/August/September, October/November/December, January/February/March, and April/May/June.

Your copay for inpatient hospital care

The inpatient hospital copay is a per-person quarterly copay. Each time you or a covered dependent is admitted to a hospital, you owe this copay. However, once you pay this copay during a calendar quarter, you won't have to pay it again for this person during the same quarter.

Example – You have coverage with CIC. You are admitted to a hospital in July and stay overnight, so you owe this copay. If you are readmitted to a hospital in September, you won't owe another copay because July and September are in the same calendar quarter. But if you are readmitted to a hospital in November, you will have to pay the copay again.

If you are readmitted to the hospital within 30 days of the date of your last hospital stay, you won't owe another inpatient hospital copay if both admissions are in the same plan year. This is true even if the two admissions occur in different calendar quarters.

Example – You are admitted to a hospital at the end of September and then readmitted in October (within 30 days of your September discharge). You don't owe another copay, even though the admissions are in different calendar quarters. But if you are readmitted to a hospital in November (more than 30 days from your September discharge), you will have to pay the copay again.

If you have two hospital admissions in different plan years, you will owe a copay for each admission, even if the readmission occurs within 30 days.

Example – You are admitted to a hospital at the end of June and then are readmitted in the beginning of July. You must pay a copay for each admission, even though the two admissions are within 30 days of each other.

Your copay for outpatient surgery

Your copay for outpatient surgery depends on where you have your surgery.

Outpatient surgery at a hospital or hospital-owned location

When you have outpatient surgery at a hospital, you owe the outpatient surgery copay. This is a per-person quarterly copay. Each time you or a covered dependent has outpatient surgery at a hospital, you owe this copay. However, once you pay this copay during a calendar quarter, you won't have to pay it again for this person during the same quarter.

> **Example** – You have outpatient surgery at a hospital in July, so you will owe the outpatient surgery copay on the hospital charges. If you have another outpatient hospital surgery in September, you won't owe another copay, because July and September are in the same calendar quarter. But if you have outpatient surgery at a hospital in November, you will have to pay the copay again.

Outpatient surgery at a non-hospital-owned location

The outpatient surgery copay applies only when you have your surgery at a hospital or hospital-owned location. There's no copay if you have your surgery at a non-hospital-owned ambulatory surgery center or doctor's office.

Copays for office visits and other services

Table 3 lists the copays you will have for office visits and services with different kinds of providers, including primary care providers and specialists.

Important! Some specialists may also provide primary care. If so, they will be considered specialists when we determine their tier and copay assignments. This means you will pay the specialist office visit copay whether you see the specialist for a primary care or specialty care visit.

Table 3. Copays for Office Visits and Other Medical Services

	With CIC	Without CIC
Copays for office visits		
Primary care With a primary care physician (PCP)[1], nurse practitioner, or physician assistant	$20	$20
Specialist – With a physician in Massachusetts		
***Tier 1 (excellent)	$30	$30
**Tier 2 (good)	$60	$60
*Tier 3 (standard)	$90	$90
Not tiered[2]	$60	$60
Specialist – With a physician outside Massachusetts	$60	$60
Specialist – With a nurse practitioner or physician assistant	$60	$60
Routine eye exam		
▪ With an optometrist	$60	$60
▪ With an ophthalmologist	See specialists (above)	See specialists (above)
Visit to an urgent care center or licensed retail medical clinic	$20	$20
Copays for other medical services	**With CIC**	**Without CIC**
Emergency room	$100 (waived if admitted)	$100 (waived if admitted)
☎ **Inpatient hospital care** This copay is waived for readmissions within 30 days of discharge, within the same plan year.	$275 per quarter	$300 per quarter
☎ **Outpatient surgery**		
▪ At a hospital or hospital-owned location	$250 per quarter	$250 per quarter
▪ At a non-hospital-owned location	No copay	No copay
▶ **Outpatient high-tech imaging, such as MRIs, CT scans, PET scans** At a hospital or non-hospital-owned location	$100 per scan (limit of one copay a day)	$100 per scan (limit of one copay a day)
☎ **Physical therapy**	$20	$20
☎ **Occupational therapy**	$20	$20
☎ **Chiropractic care**	$20	$20

1 A PCP can be a nurse practitioner, physician assistant or physician whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.

2 These are physicians who don't have enough data to allow us to score them, such as doctors who are new to practice or specialists who are not tiered through the CPI Initiative (page 78).

About coinsurance

Coinsurance is your share of the cost of a covered service when the service isn't covered at 100%. For example, if the Plan pays 80% of the allowed amount for a service, you are responsible for paying the other 20%. To find out which services have coinsurance, see Chapter 3, "Find out what's covered."

Limits to your member costs

The Plan limits how much you could pay each year for your member costs toward covered services. An **out-of-pocket limit** is the total dollar amount you could pay for member costs (deductible, copays and coinsurance) during the plan year. Once you reach these limits, UniCare pays 100% of the allowed amounts for those costs for the rest of the year.

There are three separate out-of-pocket limits, each of which applies to different services:

1. The out-of-pocket limit for **all medical services** and **in-network behavioral health services** (see Table 4).
2. The out-of-pocket limit for **out-of-network behavioral health services** (see Part 3 of this handbook).
3. The out-of-pocket limit for **prescription drugs** (see Part 2 of this handbook).

Table 4. Out-of-Pocket Limit

Dollar limits	
For an individual	$4,000 for one person each plan year
For a family	$8,000 for the entire family each plan year For any one person in the family, the dollar limit is $4,000

What is included in this out-of-pocket limit

- Deductible
- Copays and coinsurance for medical services
- Copays and coinsurance for in-network behavioral health services
- Copays and coinsurance for emergency services

What is not included in this out-of-pocket limit

- Copays and coinsurance for out-of-network behavioral health services
- Member costs for drugs and services through the prescription drug plan
- Premiums
- Balance bills (charges above the Plan's allowed amount)
- Services not covered by the Plan

About allowed amounts

UniCare reimburses a provider for a service based on the allowed amount for that service. The **allowed amount** is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. It is the maximum amount that the Plan pays for covered health care services. The Plan has established allowed amounts for most services from providers.

About balance billing

The allowed amount for a given service may not be the same as what a provider actually charges. When a provider asks you to pay for charges above the allowed amount (that is, above the amount paid by insurance), it is called **balance billing**.

The Plan doesn't cover balance bills, and balance bills don't count toward your out-of-pocket limits. By law, Massachusetts providers aren't allowed to balance bill you. However, providers in other states may do so.

See "How to use your plan wisely" on page 75 for ways to avoid being balance billed.

When you get care in Massachusetts

Massachusetts medical providers are not allowed to balance bill you for charges over the allowed amount (Massachusetts General Law, Chapter 32A: Section 20). If a Massachusetts provider balance bills you, contact UniCare Customer Service at 800-442-9300 for help resolving this issue.

If you live outside of Massachusetts

If you live outside of Massachusetts, you won't get balance billed as long as you use providers that are in the UniCare network when you get health care in your home state. Otherwise, you may be balance billed for the difference between the Plan's allowed amount and the provider's charges. Since the Plan doesn't cover balance bills, payment is your responsibility.

Behavioral health services – You must use a provider in the Beacon Health Options network to avoid getting balance billed for mental health and substance use disorder services, both in and outside of Massachusetts. Behavioral health and EAP benefits are administered by Beacon, not by UniCare. See Part 3 (pages 123-147) for information about these benefits.

When you travel

If you travel outside of either Massachusetts or the state where you live, you can be balance billed if you get medical care. Providers in other states may balance bill you for the difference between the Plan's allowed amount and what the provider charged.

If you need urgent care when you travel, you will not be balance billed as long as you go to a Travel Access provider (page 78). Keep in mind, however, that Travel Access providers are for urgent care only. If you get elective care in another state, you may be balance billed by any provider. Since the Plan doesn't cover balance bills, payment is your responsibility.

Behavioral health services – You must use a provider in the Beacon Health Options network to avoid getting balance billed for mental health and substance use disorder services, both in and outside of Massachusetts. Behavioral health and EAP benefits are administered by Beacon, not by UniCare. See Part 3 (pages 123-147) for information about these benefits.

About preferred vendors

Preferred vendors are providers who have contracted with UniCare to accept the Plan's allowed amounts. This means that you won't be balance billed as long as you use preferred vendors for the following services:

- ❑ Durable medical equipment (DME)
- ❑ Home health care
- ❑ Home infusion therapy
- ❑ Medical / diabetes supplies

Services from preferred vendors are covered at 100% of the allowed amount. Non-preferred vendors are covered at 80% and you will owe the 20% coinsurance. (Note that your deductible may also apply, no matter which type of vendor you use.)

✓ Throughout this handbook, the checkmark lets you know when to use preferred vendors.

To find UniCare preferred vendors, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

When you use non-preferred vendors

Services from non-preferred vendors are covered at 80%, so you will owe 20% coinsurance (plus your deductible, if it applies). In addition, non-preferred vendor outside of Massachusetts may balance bill you for charges over the allowed amount. Since the Plan doesn't cover balance bills, payment is your responsibility.

3: Find out what's covered

Summary of benefits

For an explanation of the symbols used in this book, see page 13.

Table 5. Summary of Covered Services

	With CIC	Without CIC	See page
Ambulance services	Deductible, then 100%	100% of the first $25, then deductible, then 80%	33
Behavioral health (mental health, substance use disorder and EAP services)	Benefits are administered by Beacon Health Options. See Part 3 of this handbook, or call Beacon at 855-750-8980 (toll free) for more information.		123
Cardiac rehabilitation programs	Deductible, then 100%	Deductible, then 100%	34
Chemotherapy	Deductible, then 100%	Deductible, then 80%	34
☎ **Chiropractic care**	$20 copay, then 80%, up to a limit of 20 visits each plan year	$20 copay, then 80%, up to a limit of 20 visits each plan year	34
✓ **Diabetes supplies**	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	38
Dialysis	Deductible, then 100%	Deductible, then 80%	39
Doctor and other health care provider services			39
▪ Primary care office visits	$20 copay, then 100%	$20 copay, then 80%	
▪ Specialist office visits	$30/60/90 copay, then 100%	$30/60/90 copay, then 80%	
▪ Inpatient hospital	Deductible, then 100%	Deductible, then 80%	
▪ Emergency room treatment	Deductible, then 100%	Deductible, then 80%	
☎ ✓ **Durable medical equipment (DME)**	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	40

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 25).

Table 5. Summary of Covered Services *(continued)*

	With CIC	Without CIC	See page
Early intervention programs	100%	100%	41
Emergency room	$100 copay, then deductible, then 100%	$100 copay, then deductible, then 100%	41
Eye care (routine)	$30/60/90 copay, then 100%; covered once every 24 months	$30/60/90 copay, then 100%; covered once every 24 months	42
Eyeglasses and contact lenses	Deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery	Deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery	43
Family planning	100%	100%	43
Fitness club reimbursement	$100 per family each plan year	$100 per family each plan year	44
Hearing aids			45
▪ Age 21 and under	100%, up to a limit of $2,000 for each impaired ear every 36 months	100%, up to a limit of $2,000 for each impaired ear every 36 months	
▪ Age 22 and over	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months	
Hearing exams	$20/30/60/90 copay, then 100%	$20/30/60/90 copay, then 80%	45
☎ ✓ **Home health care**	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	46
✓ **Home infusion therapy**	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	47
Hospice care	Deductible, then 100%	Deductible, then 100%	47
▪ Bereavement counseling	Deductible, then 80%, up to a limit of $1,500 per family	Deductible, then 80%, up to a limit of $1,500 per family	

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 25).

Table 5. Summary of Covered Services *(continued)*

	With CIC	Without CIC	See page
☎ **Inpatient care at hospitals** ▪ Semi-private room, ICU, CCU, and ancillary services	$275 quarterly copay, then deductible, then 100%	**First 120 days:** $300 quarterly copay, then deductible, then 100% **After 120th day:** 80%	50
▪ Private room (if medically necessary)	**First 90 days:** $275 quarterly copay, then deductible, then 100% **After 90th day:** 100% of the semi-private room rate	**First 90 days:** $300 quarterly copay, then deductible, then 100% **Days 91 to 120:** 100% of the semi-private room rate **After 120 days:** 80% of the semi-private room rate	
Inpatient care at other facilities, including: ▪ Chronic disease hospitals / facilities ▪ Long-term care hospitals / facilities ▪ Skilled nursing facilities ▪ Sub-acute care hospitals / facilities ▪ Transitional care hospitals / facilities	Deductible, then 80%, up to a limit of 45 days each plan year	Deductible, then 80%, up to a limit of 45 days each plan year	52
Laboratory services	Deductible, then 100%	Deductible, then 100%	52
Medical clinics (non-hospital-owned) Including urgent care centers and retail clinics	$20 copay, then 100%	$20 copay, then 80%	53
Medical services (not otherwise specified)	Deductible, then 80%	Deductible, then 80%	53
☎ **Occupational therapy**	$20 copay, then 100%	$20 copay, then 100%	54
Office visits ▪ Primary care providers	$20 copay, then 100%	$20 copay, then 80%	39
▪ Specialists	$30/60/90 copay, then 100%	$30/60/90 copay, then 80%	
Outpatient hospital services	Deductible, then 100%	Deductible, then 100%	54

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 25).

Table 5. Summary of Covered Services *(continued)*

	With CIC	Without CIC	See page
✓ **Oxygen**	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	**From preferred vendors:** Deductible, then 100% **From non-preferred vendors:** Deductible, then 80%	55
Personal Emergency Response Systems (PERS) ▪ Installation	Deductible, then 80%, up to a limit of $50	Deductible, then 80%, up to a limit of $50	55
▪ Rental fee	Deductible, then 80%, up to $40 each month	Deductible, then 80%, up to $40 each month	
☎ **Physical therapy**	$20 copay, then 100%	$20 copay, then 100%	56
Prescription drugs	Benefits are administered by CVS Caremark. See Part 2 of this handbook, or call CVS at 877-876-7214 (toll free) for more information.		107
Preventive care *See Table 6 on page 64.*	100%	100%	64
☎ **Private duty nursing (in a home setting only)**	Deductible, then 80%, up to a limit of $8,000 each plan year	Deductible, then 80%, up to a limit of $4,000 each plan year	57
Prosthetics / orthotics ▪ Breast prosthetics	Deductible, then 100%	Deductible, then 100%	57
▪ All other prosthetics and orthotics	Deductible, then 80%	Deductible, then 80%	
▶ **Radiation therapy**	Deductible, then 100%	Deductible, then 80%	58
Radiology and imaging ▪ Inpatient / emergency room	Deductible, then 100%	Deductible, then 100%	58
▪ ▶ Outpatient high-tech imaging	$100 copay, then deductible, then 100% (limit of one copay a day)	$100 copay, then deductible, then 80% (limit of one copay a day)	
▪ All other outpatient radiology	Deductible, then 100%	Deductible, then 80%	
Speech therapy	100%, up to a limit of 20 visits each plan year	80%, up to a limit of 20 visits each plan year	59

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 25).

Table 5. Summary of Covered Services *(continued)*

	With CIC	Without CIC	See page
☎ **Surgery**			60
▪ Inpatient	Deductible, then 100%	Deductible, then 80%	
▪ Outpatient at a hospital location	$250 quarterly copay, then deductible, then 100%	$250 quarterly copay, then deductible, then 80%	
▪ Outpatient at a non-hospital-owned location	Deductible, then 100%	Deductible, then 80%	
Tobacco cessation counseling	100%, up to 300 minutes each plan year	100%, up to 300 minutes each plan year	61
☎ **Transplants**			62
▪ At a Quality Center or Designated Hospital for transplants	$275 quarterly copay, then deductible, then 100%	$300 quarterly copay, then deductible, then 100%	
▪ At another hospital	$275 quarterly copay, then deductible, then 80%	$300 quarterly copay, then deductible, then 80%	

All services must be medically necessary and all charges are subject to the Plan's allowed amount for that service (page 25).

Ambulance services

Transportation by ambulance is covered, in an emergency and when medically necessary, to the nearest hospital equipped to treat the emergency condition. Covered transportation may be by ground, air or sea ambulance.

	With CIC	Without CIC
Ambulance services	Deductible, then 100%	100% of the first $25, then deductible, then 80%

Restrictions:

- Transportation to a specified or preferred facility is not covered if there is a nearer facility equipped to treat the condition. The nearest facility may be in another state or country, depending on where the emergency occurred.
- Ambulance calls for transportation that is refused is not covered.
- Transportation to medical appointments, such as dialysis treatment, is not covered.
- Transportation in chair cars or vans is not covered.

Anesthesia

Anesthesia and its administration are covered when given for a covered procedure.

	With CIC	Without CIC
Anesthesia and its administration	Deductible, then 100%	Deductible, then 80%

Restrictions:

- Anesthesia for behavioral health services is only covered for electroconvulsive therapy (ECT). Note that other charges associated with ECT are covered under your behavioral health benefit (see Part 3 of this handbook).
- There is no coverage for anesthesia used for a non-covered procedure.

Autism spectrum disorders

Autism spectrum disorders are any of the pervasive developmental disorders as defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

Medical services for autism spectrum disorders are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, pre-service review and provider payment methods. Medical services needed for diagnosis and treatment (such as occupational therapy) are covered under your medical benefit. Mental health services are covered under your behavioral health benefit. See Part 3 (pages 123-147) for additional information.

Behavioral health services

Benefits for mental health, substance use disorder and the Enrollee Assistance Program (EAP) are administered by Beacon Health Options. These services are called **behavioral health services**. See Part 3 (pages 123-147) for benefits information.

Cardiac rehabilitation programs

Cardiac rehabilitation is covered when provided through a cardiac rehabilitation program. **Cardiac rehabilitation programs** are professionally-supervised, multi-disciplinary programs to help people recover from heart attacks, heart surgery and percutaneous coronary intervention (PCI) procedures such as stenting and angioplasty. Treatment provides education and counseling services to help heart patients increase physical fitness, reduce cardiac symptoms, improve health and reduce the risk of future heart problems. The program must meet the generally accepted standards of cardiac rehabilitation.

	With CIC	Without CIC
Cardiac rehabilitation	Deductible, then 100%	Deductible, then 100%

Chemotherapy

Chemotherapy is a covered service. The drugs used in chemotherapy may be administered by injection, infusion, or orally.

	With CIC	Without CIC
Outpatient	Deductible, then 100%	Deductible, then 80%
Inpatient	Covered under the inpatient hospital benefit (page 50)	

Chiropractic care

Chiropractic care is covered, up to 20 visits each plan year, when it is used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gain exists.

	With CIC	Without CIC
Chiropractic services	$20 copay, then 80%, up to a limit of 20 visits each plan year	$20 copay, then 80%, up to a limit of 20 visits each plan year

✕ Restrictions:

- Manipulative therapy provided by a chiropractor is considered chiropractic care, not physical therapy.
- Certain manipulative therapies and physical therapy services are not covered. These include, but are not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, massage therapy, microwave therapy, paraffin treatment, rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, weight training, and therapies performed in a group setting.
- Chiropractors serving as surgical assistants or as assistant surgeons are not covered.

☎ **Notify UniCare** – Contact UniCare Customer Service at least one business day before chiropractic services start for a member under age 13. However, you don't need to notify UniCare if the member is age 13 or older.

Circumcision

Circumcision is covered for newborns up to 30 days from birth.

	With CIC	Without CIC
Circumcision	Deductible, then 100%	Deductible, then 80%

Cleft lip and cleft palate for children under 18

The treatment of cleft lip and cleft palate in children under 18 is covered if the treating physician or surgeon certifies that the services are medically necessary and are specifically for the treatment of the cleft lip or palate. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, pre-service review and provider payment methods. Benefits include:

- ❑ Audiology
- ❑ Dental (if not covered by a dental plan)
- ❑ Medical
- ❑ Nutrition services
- ❑ Oral and facial surgery
- ❑ Orthodontic treatment and management (if not covered by a dental plan)
- ❑ Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy (if not covered by a dental plan)
- ❑ Speech therapy
- ❑ Surgical management and follow-up care by oral and plastic surgeons

✕ **Restrictions:**

- There is no coverage for dental and orthodontic treatment covered by the member's dental plan.

☎ **Notify UniCare** – Contact UniCare Customer Service at least seven calendar days before services start. To access these benefits, ask to speak with a case manager when you call. (See page 84 for more information about case management.)

Clinical trials (clinical research studies)

Clinical trials are only covered for cancer treatment. The Plan covers patient care services provided within the trial only if it is a qualified clinical trial according to state law. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, pre-service review and provider payment methods.

Patient care services include items and services provided when you are enrolled in a qualified clinical trial that is consistent with your diagnosis, consistent with the study protocol for the clinical trial, and would otherwise be covered under the Plan.

To be a **qualified clinical trial**, according to state law, the clinical trial must meet all of the following conditions:

1. The clinical trial is to treat cancer.
2. The clinical trial has been peer reviewed and approved by one of the following:
   - ❑ The United States National Institutes of Health (NIH)
   - ❑ A cooperative group or center of the NIH

- ❑ A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants
- ❑ The United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption
- ❑ The United States Departments of Defense or Veterans Affairs
- ❑ With respect to Phase II, III and IV clinical trials only, a qualified institutional review board

3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.
4. With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center.
5. The member meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
6. The member has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
7. The available clinical or pre-clinical data provide a reasonable expectation that the member's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
8. The clinical trial does not unjustifiably duplicate existing studies.
9. The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the member.

The following services for cancer treatment are covered under this benefit:

1. All services that are medically necessary for treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.
2. The allowed cost, as determined by the Plan, of an investigational drug or device that has been approved for use in the clinical trial for cancer treatment to the extent it is not paid for by its manufacturer, distributor or provider, regardless of whether the FDA has approved the drug or device for use in treating your particular condition.

✕ Restrictions:

- There is no coverage for any clinical research trial other than a qualified clinical trial for the treatment of cancer.
- Patient care services do not include any of the following:
  - An investigational drug or device, except as noted above
  - Non-health care services that you may be required to receive as a result of participation in the clinical trial
  - Costs associated with managing the research of the clinical trial
  - Costs that would not be covered for non-investigational treatments
  - Any item, service or cost that is reimbursed or furnished by the sponsor of the clinical trial
  - The costs of services that are inconsistent with widely accepted and established national or regional standards of care

- The costs of services that are provided primarily to meet the needs of the trial including, but not limited to, covered tests, measurements, and other services that are being provided at a greater frequency, intensity or duration.
- Services or costs that are not covered under the Plan

Dental services

Because the Plan is a medical plan, not a dental plan, benefits for dental services are limited. UniCare provides benefits for covered services relating to dental care or surgery in the following situations only:

1. Emergency treatment from a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. Treatment is limited to trauma care and the reduction of pain and swelling, as well as any otherwise covered non-dental surgery and/or diagnostic X-rays.
2. Oral surgery for non-dental medical treatment – such as procedures to treat a dislocated or broken jaw or facial bone, and the removal of benign or malignant tumors – is covered like any other surgery.
3. The following procedures are covered when you have a serious medical condition (such as hemophilia or heart disease) that makes it necessary for you to have your dental care performed safely in a hospital, surgical day care unit, or ambulatory surgery center:
   - ❑ Extraction of seven or more teeth
   - ❑ Gingivectomies (including osseous surgery) of two or more gum quadrants
   - ❑ Excision of radicular cysts involving the roots of three or more teeth
   - ❑ Removal of one or more impacted teeth
4. The following services are covered specifically for the treatment of cleft lip or palate:
   - ❑ Dental services (if not covered by a dental plan)
   - ❑ Orthodontic treatment
   - ❑ Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic or prosthetic treatment

✕ Restrictions:

- Facility fees, anesthesia and other charges related to non-covered dental services are not covered.
- Dentures, dental prosthetics and related surgery are not covered.
- Orthodontic treatment, including treatment done in preparation for surgery, is not covered.

Diabetes care

Coverage for diabetes care applies to services prescribed by a doctor for insulin-dependent, insulin-using, gestational and non-insulin-using diabetes. Covered services include outpatient self-management training and patient management, as well as nutritional therapy.

Patient management refers to outpatient education and training for a person with diabetes, given by a person or entity with experience in treating diabetes. It is done in consultation with your physician, who must certify that the services are part of a comprehensive care plan related to your condition. The services must also be needed to ensure therapy or compliance, or to give you the skills and knowledge necessary to successfully manage your condition.

Diabetes self-management training and patient management, including nutritional therapy, may be conducted individually or in a group. It must be provided by an education program recognized by the American Diabetes Association or by a Certified Diabetes Educator® (CDE®). Coverage includes all educational materials for the program.

Benefits are available in the following situations:

- ❑ You are initially diagnosed with diabetes
- ❑ Your symptoms or condition change significantly, requiring changes in self-management
- ❑ You need refresher patient management
- ❑ You are prescribed new medications or treatment

Screenings for Type 2 and gestational diabetes are covered as preventive services (page 65).

Diabetes supplies

Diabetes supplies are covered when prescribed by a doctor for insulin-dependent, insulin-using, gestational and non-insulin-using diabetes.

	With CIC	Without CIC
Diabetes supplies	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%

The following diabetes supplies are covered under the medical benefit:

- ❑ Blood glucose monitors, including voice synthesizers for blood glucose monitors for use by legally blind persons
- ❑ Insulin infusion devices
- ❑ Insulin measurement and administration aids for the visually impaired
- ❑ Insulin pumps and all related supplies
- ❑ Laboratory tests, including glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin and lipid profiles
- ❑ Lancets and lancet devices
- ❑ Podiatric appliances for the prevention of complications associated with diabetes
- ❑ Syringes and all injection aids
- ❑ Test strips for glucose monitors
- ❑ Urine test strips

Diabetes drugs (such as insulin and prescribed oral agents) and many supplies are covered under your prescription drug plan. See Part 2 of this handbook (pages 107-121).

✓ **Use preferred vendors** (page 27) – Supplies from UniCare preferred vendors are covered at 100% of the allowed amount. Supplies from non-preferred vendors are covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

To find UniCare preferred vendors, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Important! Non-preferred vendors are covered at 80%, even if you are using the non-preferred vendor because the item isn't available from a preferred vendor.

Dialysis

Dialysis treatment, including hemodialysis and peritoneal dialysis, is covered.

	With CIC	Without CIC
Dialysis	Deductible, then 100%	Deductible, then 80%

✕ Restrictions:

- Transportation to appointments for dialysis treatment is not covered.

Doctor and other health care provider services

Medically necessary services from a licensed provider are covered when that provider is acting within the scope of his or her license. The services must be provided in a hospital, clinic, professional office, home care setting, long-term care setting, or other medical facility.

	With CIC	Without CIC
Primary care office visits	$20 copay, then 100%	$20 copay, then 80%
Specialist office visits	$30/60/90 copay, then 100%	$30/60/90 copay, then 80%
Inpatient hospital	Deductible, then 100%	Deductible, then 80%
Emergency treatment	Deductible, then 100%	Deductible, then 80%

Covered providers include any of the following acting within the scope of their licenses or certifications:

- ❑ Certified nurse midwives
- ❑ Chiropractors
- ❑ Dentists
- ❑ Nurse practitioners
- ❑ Optometrists
- ❑ Physician assistants
- ❑ Physicians
- ❑ Podiatrists

✕ Restrictions:

- Covered telehealth services are limited to the delivery of services through the use of interactive audio-visual, or other interactive electronic media, for the purpose of diagnosis, consultation, and/or treatment of a patient in a location separate from the provider. There is no coverage for audio-only telephone consultations, email consultations, or services obtained from websites or from providers over the Internet.
- There is no coverage for physicians to be available in case their services are needed, such as a stand-by physician in an operating room. The Plan only pays providers for the actual delivery of medically necessary services.

Durable medical equipment (DME)

Durable medical equipment (DME) is covered if the service or supply is medically necessary, prescribed by a physician, and meets the Plan's definition of DME. Such equipment includes wheelchairs, crutches, oxygen and respiratory equipment.

To meet the Plan's definition of **durable medical equipment (DME)**, the service or supply must be:

1. Provided by a DME supplier
2. Designed primarily for therapeutic purposes or to improve physical function
3. Provided in connection with the treatment of disease, injury or pregnancy upon the recommendation and approval of a physician
4. Able to withstand repeated use, and
5. Ordered by a physician

	With CIC	Without CIC
Breast pumps	▪ **From preferred vendors:** 100% ▪ **From non-preferred vendors:** 80%	▪ **From preferred vendors:** 100% ▪ **From non-preferred vendors:** 80%
All other DME	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%

The Plan covers the rental of DME up to the purchase price. If the Plan determines that the purchase cost is less than the total expected rental charges, it may decide to purchase such equipment for your use.

✕ Restrictions:

- There is no coverage for personal comfort items related to activities of daily living that could be purchased without a prescription. These items include, but are not limited to: air conditioners, air purifiers, arch supports, bed pans, blood pressure monitors, commodes, corrective shoes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, telephones, televisions, whirlpools or spas, and other similar items.
- The following items are not covered: blood pressure cuffs (sphygmomanometers), computer-assisted communications devices, incontinence supplies, lift or riser chairs, molding helmets, non-hospital beds, orthopedic mattresses, stairway lifts, stair ramps, and thermal therapy devices (hot or cold).
- If you choose to rent DME after UniCare determines that it would cost less to purchase it, you will not be covered for rental charges that exceed the purchase price.
- Oxygen equipment required for use on an airplane or other means of travel is not covered.

☎ **Notify UniCare** – Contact UniCare Customer Service at least one business day before ordering equipment that is expected to cost more than $500. The $500 cost may be the purchase price or the total rental charges. You don't need to provide notice for oxygen or oxygen equipment.

▶ **Notify AIM** – For BPAP and CPAP equipment, your provider must notify AIM Specialty Health.

✓ **Use preferred vendors** (page 27) – DME and related supplies from UniCare preferred vendors are covered at 100% of the allowed amount. DME and related supplies from non-preferred vendors are covered at 80%, and you owe 20% coinsurance. Your deductible applies to both types of vendors.

To find UniCare preferred vendors, go to the *Members* page at unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Important! Non-preferred vendors are covered at 80%, even if you are using the non-preferred vendor because the item isn't available from a preferred vendor.

Early intervention programs for children

Coverage is provided for medically necessary early intervention services for children from birth until their third birthday.

Early intervention services include occupational, physical and speech therapy, nursing care and psychological counseling. These services must be provided by licensed or certified health care providers working within an early intervention services program approved by the Massachusetts Department of Public Health, or under a similar law in other states.

	With CIC	Without CIC
Early intervention services	100%	100%

Emergency room

The Plan will cover medical and transportation expenses incurred as a result of an emergency medical condition.

An **emergency** is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child.

	With CIC	Without CIC
Emergency room	$100 copay, then deductible, then 100% (copay is waived if admitted)	$100 copay, then deductible, then 100% (copay is waived if admitted)
Laboratory testing	Deductible, then 100%	Deductible, then 100%
Radiology	Deductible, then 100%	Deductible, then 100%

Massachusetts provides a 911 emergency response system throughout the state. If you are faced with an emergency, call 911. In other states, check with your local telephone company about emergency access numbers. Keep emergency numbers and the telephone numbers of your physicians in an easily accessible location.

✗ **Restrictions:**

- Services received at a medical clinic, such as an urgent care center, are not covered as emergency room care.
- Non-emergency services performed at an emergency room are covered at the non-emergency benefit level. This means that, depending on what the service is, there may be a notification requirement, and you may also owe a copay and/or coinsurance.

☎ **Notify UniCare** – If you are admitted to the hospital from the emergency room, you or someone acting for you must notify UniCare Customer Service within 24 hours of, or the next business day after, being admitted.

Enteral therapy

Enteral therapy is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Prescription and nonprescription enteral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

	With CIC	Without CIC
Enteral therapy	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%

☎ **Notify UniCare** – Contact UniCare Customer Service at least one business day before services start.

✓ **Use preferred vendors** (page 27) – Enteral therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, enteral therapy is covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

To find UniCare preferred vendors, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Eye care

Routine eye exams consisting of refraction and glaucoma testing are covered once every 24 months.

	With CIC	Without CIC
Routine eye exams Refraction / glaucoma testing	$30/60/90 copay, then 100%; covered once every 24 months	$30/60/90 copay, then 100%; covered once every 24 months
Eye care office visits When medically necessary	$30/60/90 copay, then 100%	$30/60/90 copay, then 80%

✕ Restrictions:

- Routine eye exams consist of refraction and glaucoma testing only. Other testing – such as visual fields, ophthalmoscopy or ophthalmic diagnostic imaging – is not considered routine.
- Vision therapy is not covered.
- There is no coverage for vision care including orthoptics for vision correction, radial keratotomy and related laser surgeries; any other surgeries, services or supplies furnished in conjunction with the determination or correction of refractive errors such as astigmatism, myopia, hyperopia and presbyopia.

Eyeglasses and contact lenses

Generally, the Plan does not cover eyeglasses or contact lenses. However, a set of eyeglasses or contact lenses is covered after an eye injury or cataract surgery that implants an intraocular lens (IOL). Standard frames and lenses, including bifocal and trifocal lenses, are covered when purchased within six months after surgery.

	With CIC	Without CIC
Eyeglasses and contact lenses	Deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery	Deductible, then 80%; limited to the initial lenses within six months after an eye injury or cataract surgery

✕ Restrictions:

- Eyeglasses and contact lenses are only covered within six months after an eye injury or cataract surgery. Coverage applies to the initial lenses only.
- There is no coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses.
- Monofocal intraocular lenses (IOLs) implanted in the eye after the removal of cataracts are covered when you have cataract surgery. However, there is no coverage for presbyopia-correcting IOLs (IOLs that restore vision in a range of distances). Multifocal IOLs and accommodating IOLs are both types of presbyopia-correcting IOLs and are also not covered.

Family planning

Family planning services, including office visits and procedures for the purpose of contraception, are covered.

	With CIC	Without CIC
Office visits	100%	100%
Procedures	100%	100%

Office visits include evaluations, consultations and follow-up care.

Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA-approved contraceptive drugs and devices are available through your prescription drug plan (see Part 2 of this handbook).

When voluntary sterilization or voluntary termination of pregnancy is performed at a physician's office, the specialist copay may apply; when performed in an outpatient surgery setting, the outpatient surgery copay may apply.

Fitness club reimbursement

You can get reimbursed for up to $100 per family on your membership at a fitness club. **Fitness clubs** include health clubs and gyms that offer cardio and strength-training machines and other programs for improved physical fitness.

	With CIC	Without CIC
Fitness club reimbursement	$100 per family each plan year	$100 per family each plan year

The fitness reimbursement is paid once each plan year as a lump sum to the plan enrollee, upon proof of membership and payment.

Use the form in Appendix B to submit a request for the fitness reimbursement. You can also download the form from unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 to request a copy.

✕ Restrictions:

- Although any family member may have the fitness membership, the reimbursement is a one-time payment each plan year and is made to the plan enrollee only.
- Fitness clubs are limited to health clubs or gyms that offer cardio and strength-training machines, and other programs for improved physical fitness. Martial arts centers, gymnastics centers, country clubs, beach clubs, sports teams and leagues, and tennis clubs are not considered fitness clubs.
- There is no fitness reimbursement benefit for personal trainers, sports coaches, yoga classes or exercise machines.

Foot care (routine)

Routine foot care, such as nail trimming and callus removal, is not covered unless a medical condition affecting the lower limbs (such as diabetes or peripheral vascular disease of the lower limbs) makes the care medically necessary.

- ❑ If you are ambulatory, medical evidence must document an underlying condition causing vascular compromise, such as diabetes.
- ❑ If you are not ambulatory, medical evidence must document a condition that is likely to result in significant medical complications in the absence of such treatment.

	With CIC	Without CIC
Routine foot care	▪ **With a PCP:** $20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then 80% ▪ **With a specialist:** $30/60/90 copay, then 80%

✕ Restrictions:

- Arch supports are not covered.

Gynecology exams

Gynecological exams, including Pap smears, are covered every 12 months as a preventive service. Other medically necessary gynecology services are covered under the benefit for provider office visits.

	With CIC	Without CIC
Annual exam, with Pap smear	100%	100%
Office visits	▪ **With a PCP:** $20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then 80% ▪ **With a specialist:** $30/60/90 copay, then 80%

Hearing aids

Hearing aids are covered when prescribed by a physician.

	With CIC	Without CIC
Age 21 and under	100%, up to a limit of $2,000 for each impaired ear every 36 months	100%, up to a limit of $2,000 for each impaired ear every 36 months
Age 22 and over	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months	100% of the first $500, then 80% of the next $1,500, up to a limit of $1,700 every 24 months

✕ Restrictions:

- Ear molds are not covered, except when needed for hearing aids for members age 21 and under.
- Hearing aid batteries are not covered.

Hearing exams

Expenses for hearing exams for the diagnosis of speech, hearing and language disorders are covered when provided by a physician or a licensed audiologist. The exam must be administered in a hospital, clinic or private office.

	With CIC	Without CIC
Hearing exams	▪ **With a PCP:** $20 copay, then 100% ▪ **With a specialist:** $30/60/90 copay, then 100%	▪ **With a PCP:** $20 copay, then 80% ▪ **With a specialist:** $30/60/90 copay, then 80%
Hearing screenings for newborns	100%	100%

✕ Restrictions:

- Services provided in a school-based setting are not covered.
- There is no coverage for services that a school system is obligated to provide under Massachusetts Special Education Law (M.G.L. c. 71(b)) known as Chapter 766, or under similar laws in other states.

Home health care

Benefits are provided for skilled services provided under a plan of care prescribed by a physician and delivered by a visiting nurse association or a Medicare-certified home health care agency. These services and supplies must be provided in a residential, non-institutional setting while you are confined as a result of injury, disease or pregnancy.

Home health care means any health services and supplies provided by a home health care agency on a part-time, intermittent or visiting basis.

A **plan of care** is a written order from a physician outlining services to be provided in the home. A plan of care is subject to review and approval by the Plan.

A **visiting nurse association (VNA)** is an agency that is certified by Medicare to provide part-time, intermittent skilled care and other home care services in a person's place of residence. VNAs must be licensed in any jurisdiction which requires such licensing.

	With CIC	Without CIC
Home health care	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%

The following services are only covered if you are getting approved part-time, intermittent skilled care furnished or supervised by a registered nurse or licensed physical therapist:

- ❑ Durable medical equipment (DME) and related supplies provided as a medically necessary component of an approved plan of care are covered under the DME benefit (page 40)
- ❑ Medical social services provided by a licensed medical social worker
- ❑ Nutritional consultation by a registered dietitian
- ❑ Part-time, intermittent home health aide services consisting of personal care and help with activities of daily living
- ❑ Physical, occupational, speech and respiratory therapy by the appropriate licensed or certified therapist

✕ **Restrictions:**

- Charges for custodial care or homemaking services are not covered.
- There is no coverage for services provided by you, a member of your family or any person who resides in your home. Your family consists of you, your spouse and your children, as well as brothers, sisters and parents of both you and your spouse.

☎ **Notify UniCare** – Contact UniCare Customer Service at least one business day before services start.

✓ **Use preferred vendors** (page 27) – Home health services from a UniCare preferred vendor are covered at 100% of the allowed amount. From non-preferred vendors, home health services are covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

To find UniCare preferred vendors, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Home infusion therapy

Home infusion therapy is the administration of intravenous, subcutaneous or intramuscular therapies provided in a residential, non-institutional setting. To be considered for coverage, home infusion therapy must be delivered by a company that is licensed as a pharmacy and is qualified to provide home infusion therapy.

	With CIC	Without CIC
Home infusion therapy	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%

✗ **Restrictions:**

- Non-oncology infused drugs require prior review and are dispensed by the prescription drug plan (see Part 2 of this handbook).
- Subcutaneous and intramuscular drugs must be obtained through your prescription drug plan.

✓ **Use preferred vendors** (page 27) – Home infusion therapy from a UniCare preferred vendor is covered at 100% of the allowed amount. From non-preferred vendors, home infusion therapy is covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

To find UniCare preferred vendors, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Hospice care

Hospice benefits are payable for covered hospice care services in a Medicare-certified hospice program when a physician certifies (or re-certifies) that you are terminally ill. The services must be furnished under a written plan of hospice care, established by a hospice and periodically reviewed by the medical director and interdisciplinary team of the hospice. Concurrent chemotherapy and radiation therapy, if palliative, are permitted.

A **hospice** is a public agency or a private organization that provides care and services for terminally ill persons and their families and is certified as such by Medicare.

A **terminal illness** is an illness that, because of its nature, can be expected to cause your death. You are considered terminally ill when given a medical prognosis of twelve months or less to live.

	With CIC	Without CIC
Hospice care	Deductible, then 100%	Deductible, then 100%
Bereavement counseling	Deductible, then 80%, up to a limit of $1,500 per family	Deductible, then 80%, up to a limit of $1,500 per family

The Plan covers the following hospice care services:

1. Part-time, intermittent nursing care provided by or supervised by a registered nurse
2. Physical, respiratory, occupational and speech therapy from an appropriately licensed or certified therapist
3. Medical social services

4. Part-time, intermittent services of a home health aide under the direction of a registered nurse
5. Necessary medical supplies and medical appliances
6. Drugs and medications prescribed by a physician and charged by the hospice
7. Laboratory services
8. Physicians' services
9. Transportation needed to safely transport you to the place where you are to receive a covered hospice care service
10. Psychological, social and spiritual counseling for the member furnished by one of the following:
    - ❑ Physician
    - ❑ Psychologist
    - ❑ Member of the clergy
    - ❑ Registered nurse
    - ❑ Social worker
11. Dietary counseling from a registered dietitian
12. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home. **Respite care services** are services rendered to a hospice patient to relieve the family or primary care person from caregiving functions.
13. Bereavement counseling furnished to surviving members of a terminally ill person's immediate family or other persons specifically named by a terminally ill person. Bereavement counseling must be furnished within twelve months after the date of death and must be provided by one of the following:
    - ❑ Physician
    - ❑ Psychologist
    - ❑ Member of the clergy
    - ❑ Registered nurse
    - ❑ Social worker

✕ Restrictions:

- Respite care is limited to a total of five days.
- Bereavement counseling is limited to $1,500 per family. Additional bereavement services may be available under the behavioral health benefit (see pages 123-147).
- No hospice benefits are payable for services not listed in this section, nor for any service furnished by a volunteer, or for which no charge is customarily made.

Infertility treatment

Non-experimental infertility procedures are covered services. These procedures are recognized as generally accepted and/or non-experimental by the American Fertility Society and the American College of Obstetrics and Gynecology.

Infertility occurs when a healthy female is unable to conceive:

- ❑ If age 35 or under: During a period of one year, unless the condition is caused by or is the result of voluntary sterilization or the normal aging process
- ❑ If over age 35: During a period of six months, unless the condition is caused by or is the result of voluntary sterilization or the normal aging process

If a woman conceives but is unable to carry the pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one-year or six-month period, as applicable.

Covered infertility procedures include but are not limited to:

- ❑ Artificial insemination (AI), also known as intrauterine insemination (IUI)
- ❑ Cryopreservation of eggs as a component of covered infertility treatment. Costs associated with banking and/or storing inseminated eggs are reimbursable only upon the use of such eggs for covered fertility treatment.
- ❑ Donor sperm or egg procurement and processing, to the extent such costs are not covered by the donor's insurer
- ❑ Gamete intrafallopian transfer (GIFT)
- ❑ Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility
- ❑ In vitro fertilization and embryo placement (IVF-EP)
- ❑ Natural ovulation intravaginal fertilization (NORIF)
- ❑ Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer
- ❑ Zygote intrafallopian transfer (ZIFT)

✕ Restrictions:

- Experimental infertility procedures are not covered.
- In vitro fertilization and other associated infertility procedures, with the exception of artificial insemination, are limited to five attempts. An **attempt** is defined as the initiation of a reproductive cycle with the expectation of implanting a fertilized ovum. The occurrence of either of the following events constitutes an attempt:
  - Starting drug therapy to induce ovulation, or
  - Operative procedures for the purpose of implantation of a fertilized ovum
- Reversal of voluntary sterilization is not covered.
- Shipping costs, such as the cost of shipping eggs or sperm between clinics, are not covered.
- Procurement and processing of sperm, eggs, and/or inseminated eggs, and banking of sperm or inseminated eggs, are covered only for the treatment of infertility.
- There is no coverage for any medical services, including in vitro fertilization, in connection with the use of a gestational carrier or surrogate.
- Facility fees are covered only for a licensed hospital or ambulatory surgery center.
- There is no coverage for procedures for infertility not meeting the definition of infertility shown above.

Inpatient care at hospitals

Inpatient hospital care is covered for a hospital stay at an acute medical facility, a surgical facility, or a rehabilitation facility. A **hospital stay** is defined as the time a person is confined to a hospital and incurs a room and board charge for inpatient care.

	With CIC	Without CIC
Semi-private room, ICU, CCU, and ancillary services	$275 quarterly copay, then deductible, then 100%	▪ **First 120 days:** $300 quarterly copay, then deductible, then 100% ▪ **After 120th day:** 80%
Private room When medically necessary	▪ **First 90 days:** $275 quarterly copay, then deductible, then 100% ▪ **After 90th day:** 100% of the semi-private room rate	▪ **First 90 days:** $300 quarterly copay, then deductible, then 100% ▪ **Days 91 to 120:** 100% of the semi-private room rate ▪ **After 120 days:** 80% of the semi-private room rate
Diagnostic laboratory and radiology expenses	Deductible, then 100%	Deductible, then 100%

Charges for the following services are covered if the services are for a hospital stay:

1. Your room and board
2. Anesthesia, radiology and pathology services
3. Hospital pre-admission testing if you are scheduled to enter the same hospital where the tests are performed within seven days of the testing. If the hospital stay is cancelled or postponed after the tests are performed, the charges will still be covered as long as the physician presents a satisfactory medical explanation.
4. Medically necessary services and supplies charged by the hospital
5. Physical, occupational and speech therapy
6. Diagnostic and therapeutic services

Ancillary services are also covered. These are the services and supplies that a facility ordinarily renders for diagnosis or treatment during your hospital stay, including:

- ❑ Administration of infusions and transfusions
- ❑ Devices that are an integral part of a surgical procedure such as hip joints, skull plates and pacemakers
- ❑ Drugs, medications, solutions, biological preparations, and medical and surgical supplies used during your hospital stay
- ❑ Tests and exams
- ❑ Use of special equipment in the facility
- ❑ Use of special rooms, such as operating or treatment rooms

✕ Restrictions:

- Custodial care and special nursing or physician services are not covered.
- The cost of whole blood, packed red cells, and blood donor fees are not covered.
- Devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids may be covered under a different benefit, such as prosthetics.

☎ **Notify UniCare** – UniCare must review all inpatient hospital admissions. You or someone acting for you must contact UniCare Customer Service at least seven days before a non-emergency admission, and within 24 hours of, or the next business day after, an emergency or maternity admission.

Reviews for hospital admissions

Initial review

The purpose of the initial review is to let you know if your admission is eligible for benefits under the Plan. Calling UniCare Customer Service reduces your risk of having to pay for non-covered services. Once Customer Service has been notified, a nurse reviewer may call your provider for clinical information to help with the review process.

The Plan will make an initial determination within two business days of getting all necessary information.

As soon as a decision has been made, UniCare will contact your provider directly. For an emergency admission, UniCare will contact the hospital directly. In addition, both you and your provider will be notified in writing to confirm that the hospitalization is eligible for benefits under the Plan. The written notice will also specify the initial length of stay that has been approved.

If the nurse reviewer is unable to make a determination, your provider will be offered the opportunity to speak with a physician advisor. Once a decision is made, UniCare will contact your provider directly and you will be notified in writing. If you disagree with the decision, you may appeal (see Appendix D).

Continued stay review

Your provider may recommend that you stay in the hospital beyond the initial number of days that the Plan has approved. In this case, the Plan will determine whether a continued hospital stay is eligible for benefits under the Plan.

You don't need to contact UniCare if your provider recommends that you stay in the hospital longer. During your continued stay, the nurse reviewer will work with the hospital staff to facilitate planning for care that may be required after your discharge.

If the nurse reviewer is unable to make a determination about your continued hospitalization, your provider will be offered the opportunity to speak with a physician advisor. Once a decision is made, UniCare will contact your provider directly and you will be notified in writing. If you disagree with the decision, you may appeal (see Appendix D).

Inpatient care at other facilities

Care at **other inpatient facilities** is covered. Inpatient facilities covered under this benefit are:

- ❑ Chronic disease hospitals / facilities
- ❑ Long-term care hospitals / facilities
- ❑ Skilled nursing facilities
- ❑ Sub-acute care hospitals / facilities
- ❑ Transitional care hospitals / facilities

	With CIC	Without CIC
Inpatient care at other facilities	Deductible, then 80%, up to a limit of 45 days each plan year	Deductible, then 80%, up to a limit of 45 days each plan year

To qualify for coverage in other inpatient facilities, the purpose of the care in these facilities must be the reasonable improvement in your condition. A physician must certify that you need and receive, at a minimum, skilled nursing or skilled rehabilitation services on a daily or intermittent basis.

Covered charges for these facilities include the following services:

1. Room and board
2. Routine nursing care
3. Physical, occupational and speech therapy provided by the facility or by others under arrangements with the facility
4. Drugs, biologicals, medical supplies, appliances, and equipment that are ordinarily provided by the facility for the care and treatment of its patients
5. Medical social services
6. Diagnostic and therapeutic services furnished at the facility by a hospital or health care provider
7. Other medically necessary services that are generally provided by such treatment facilities

✕ Restrictions:

- Services provided by a private duty nurse or other private duty attendant are not covered.
- There is no coverage for continuing care for a person who has not demonstrated reasonable clinical improvement.

Laboratory services

Diagnostic laboratory services are covered when they are prescribed by a physician.

	With CIC	Without CIC
Diagnostic lab services	Deductible, then 100%	Deductible, then 100%
Preventive lab services	100%, according to the preventive care schedule (pages 64-67)	

Maternity services

Maternity services are covered like any other physical condition. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, pre-service review and provider payment methods. Medical services needed for diagnosis and treatment are covered under your medical benefit.

Medical clinics (non-hospital-owned)

Services at non-hospital-owned medical clinics – such as retail medical clinics and urgent care centers – are covered for medically necessary episodic or urgent care. These clinics are limited to providing care within the scope of their license in the state where they operate.

Urgent care is defined as care needed for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. Earaches and sinus infections are examples of conditions that may require urgent care.

Important! These benefits only apply to non-hospital-owned medical clinics. Clinics owned and operated by hospitals are hospital facilities, whether located in a hospital or elsewhere. These facilities may bill your visit as an emergency room visit. The presence of a hospital name usually indicates that the site is a hospital facility.

	With CIC	Without CIC
Medical clinics (non-hospital-owned) Including urgent care centers and retail clinics	$20 copay, then 100%	$20 copay, then 80%

Retail medical clinics are licensed medical clinics, typically located at certain pharmacies, that provide basic primary medical services from nurse practitioners or physician assistants.

Walk-in clinics are independent, stand-alone facilities that accept patients on a walk-in basis, with no appointment required. **Urgent care centers** are one type of walk-in clinic. At urgent care centers, groups of providers treat conditions that should be checked right away but aren't as severe as emergencies. They can often do X-rays, lab tests and stitches.

Restrictions:

- Services at hospital-owned medical clinics may be covered as emergency room care (page 41) or outpatient hospital care (page 54), depending on how the services are billed.

Medical services (not otherwise specified)

Important! This section applies only to covered medical services that aren't addressed elsewhere in this chapter. Be sure to check the index to see if the benefits for a particular service are described in a different section.

	With CIC	Without CIC
Covered medical services (not otherwise specified)	Deductible, then 80%	Deductible, then 80%

Nutritional counseling

Nutritional counseling services are covered only under the circumstances listed below. Services must be provided by a registered dietician.

- ❑ Adults at high risk for cardiovascular disease are covered for up to three visits a year under the preventive benefit (page 65).
- ❑ Children under 18 are covered as part of being treated for cleft lip or cleft palate (page 35).
- ❑ Members with diabetes are covered under the benefit for diabetes care (page 37).
- ❑ Members with certain eating disorders are covered for ongoing counseling. Note that other charges for the treatment of eating disorders may be covered under the behavioral health benefit (see Part 3 of this handbook).

Occupational therapy

Occupational therapy is covered when ordered by a physician and performed by a registered occupational therapist.

Occupational therapy is skilled treatment that helps individuals achieve independence with activities of daily living after an illness or injury not incurred during the course of employment. Services include:

- ❑ Treatment programs aimed at improving the ability to carry out activities of daily living
- ❑ Comprehensive evaluations of the home
- ❑ Recommendations and training in the use of adaptive equipment to replace lost function

	With CIC	Without CIC
Occupational therapy	$20 copay, then 100%	$20 copay, then 100%

✕ **Restrictions:**

- Group occupational therapy is not covered.

☎ **Notify UniCare** – Contact UniCare Customer Service at least one business day before services start.

Outpatient hospital services

Important! This section applies only to outpatient services that aren't addressed elsewhere in this chapter. Be sure to check the index to see if the benefits for a particular outpatient service are described in a different section.

Outpatient hospital services are services that are provided by a hospital but that don't require inpatient admission. Outpatient services are usually performed within a single day and don't require an overnight stay. However, an overnight stay for observation would be considered outpatient care if you are not actually admitted to the hospital.

	With CIC	Without CIC
Outpatient hospital services	Deductible, then 100%	Deductible, then 100%

Oxygen

Oxygen and its administration are covered.

	With CIC	Without CIC
Oxygen	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%	▪ **From preferred vendors:** Deductible, then 100% ▪ **From non-preferred vendors:** Deductible, then 80%

✗ Restrictions:

- Oxygen equipment required for use on an airplane or other means of travel is not covered.

✓ **Use preferred vendors** (page 27) – Supplies from UniCare preferred vendors are covered at 100% of the allowed amount. From non-preferred vendors, supplies are covered at 80% and you owe 20% coinsurance. Your deductible applies to both types of vendors.

To find UniCare preferred vendors, go to the *Members* page of unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Important! Non-preferred vendors are covered at 80%, even if you are using the non-preferred vendor because the item isn't available from a preferred vendor.

Palliative care

Palliative care is care that focuses on treating symptoms – like severe pain, or difficulty breathing – to make you more comfortable. It is not intended to cure underlying conditions.

Palliative care is covered like any other physical condition. Medical services are covered under your medical benefit. Coverage is subject to all pertinent provisions of the Plan, including use of participating providers, pre-service review and provider payment methods.

Personal Emergency Response Systems (PERS)

Benefits are payable for the rental of a personal emergency response system (PERS) if all of the following are true:

1. The PERS unit is provided by a hospital
2. You are homebound
3. You are alone at least four hours a day, five days a week, and are functionally impaired

	With CIC	Without CIC
Installation	Deductible, then 80%, up to a limit of $50	Deductible, then 80%, up to a limit of $50
Rental fee	Deductible, then 80%, up to a limit of $40 each month	Deductible, then 80%, up to a limit of $40 each month

✗ Restrictions:

- No benefits are payable for the purchase of a PERS unit.

Physical therapy (manipulative therapy)

Benefits are provided for physical therapy used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gain exists. **Physical therapy** (**manipulative therapy**) is hands-on treatment provided by a licensed physical therapist by means of direct manipulation, exercise, movement or other physical modalities to relieve pain, restore function and/or minimize disability that is the result of disease or injury to the neuromuscular and/or musculoskeletal system, or following the loss of a body part.

The Plan only covers one-on-one therapies rendered by a registered physical therapist or certified physical therapy assistant (under the direction of a physical therapist) when ordered by a physician.

	With CIC	Without CIC
Physical therapy	$20 copay, then 100%	$20 copay, then 100%

✕ Restrictions:

- Certain manipulative therapies and physical therapy services are not covered. These include, but are not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, massage therapy, microwave therapy, paraffin treatment, rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, weight training, and therapies performed in a group setting.
- Group physical therapy is not covered.
- Manipulative therapy provided by a chiropractor is considered chiropractic care, not physical therapy.
- Massage therapy and services provided by a massage therapist or neuromuscular therapist are not covered.
- Services provided by athletic trainers, including physical therapy, are not covered.

☎ **Notify UniCare** – Contact UniCare Customer Service at least one business day before services start.

Prescription drugs

Benefits for prescription drugs are administered by CVS Caremark. See Part 2 (pages 107-121) for benefits information.

Preventive care

The Plan covers preventive or routine level office visits, physical examinations and other related preventive services that are recommended by the U.S. Preventive Services Task Force. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

The complete schedule of preventive services appears on pages 64-67.

	With CIC	Without CIC
Preventive care	100%	100%

✕ Restrictions:

- EKG (electrocardiogram) done solely for the purpose of screening or prevention is not covered.

Private duty nursing

Benefits are provided for highly skilled nursing services needed continuously during a block of time (greater than two hours) when you are confined to your home.

	With CIC	Without CIC
Private duty nursing	Deductible, then 80%, up to a limit of $8,000 each plan year	Deductible, then 80%, up to a limit of $4,000 each plan year

Private duty nursing services must:

1. Be medically necessary
2. Provide skilled nursing services by a registered nurse
3. Be exclusive of all other home health care services, and
4. Not duplicate services that a hospital or facility is licensed to provide

For plans with CIC, up to $4,000 (of the $8,000 limit) may be for licensed practical nurse (LPN) services if no registered nurse is available.

✕ **Restrictions:**

- Outpatient private duty nursing is provided only at your home, when you are confined to your home.
- Private duty nursing services in a hospital or any other inpatient facility are not covered.
- Custodial care is not covered. **Custodial care** is defined as a level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

☎ **Notify UniCare** – Contact UniCare Customer Service at least one business day before services start.

Prosthetics and orthotics

Prosthetic and orthotic items, including braces, are covered if they are prescribed by a physician as medically necessary.

Prosthetics replace part of the body or replace all or part of the function of a permanently inoperative, absent, or impaired part of the body. Breast prosthetics and artificial limbs are prosthetics.

Orthotics are supportive appliances used to restrict, align or correct deformities and/or to improve the function of movable parts of the body. They are frequently attached to clothing and/or shoes, may assist in locomotion, and are sometimes jointed. Orthotics include **braces**, splints and trusses.

	With CIC	Without CIC
Breast prosthetics	Deductible, then 100%	Deductible, then 100%
Orthopedic shoe with attached brace	Deductible, then 100%	Deductible, then 100%
All other prosthetics and orthotics	Deductible, then 80%	Deductible, then 80%

Orthotics must be:

- ❑ Ordered by a physician
- ❑ Custom fabricated (molded and fitted) to your body
- ❑ Used only by you

✕ Restrictions:

- There is no coverage for replacement prosthetics and orthotics except when needed due to normal growth or pathological change (a change in your medical condition that requires a prescription change). Supporting documentation is required.
- The following items and services are not covered:
  - Arch supports
  - Charges for test or temporary orthotics
  - Charges for video tape gait analysis and diagnostic scanning
  - Orthopedic / corrective shoes that do not attach directly to a brace

Radiation therapy

Radiation therapy, including radioactive isotope therapy and intensity-modulated radiation therapy (IMRT), is a covered service.

	With CIC	Without CIC
Radiation therapy	Deductible, then 100%	Deductible, then 80%

▶ **Notify AIM** – Your provider must contact AIM Specialty Health at least seven days before services start.

Radiology and imaging services

Radiology services include **high-tech imaging** which are tests that vary from plain film X-rays by offering providers a more comprehensive view of the human body. Many of these tests also subject members to significantly higher levels of radiation compared to plain film X-rays and are also much more expensive. These procedures include, but are not limited to, MRIs, CT scans and PET scans.

	With CIC	Without CIC
Inpatient and emergency room Including high-tech imaging	Deductible, then 100%	Deductible, then 100%
Outpatient high-tech imaging Such as MRIs, CT scans and PET scans	$100 copay, then deductible, then 100% (limit of one copay a day)	$100 copay, then deductible, then 80% (limit of one copay a day)
All other outpatient radiology Such as X-rays	Deductible, then 100%	Deductible, then 80%

▶ **Notify AIM** – For high-tech imaging procedures, your provider must notify AIM Specialty Health at least seven days before the procedure. However, no notice is needed for any other radiology or imaging services.

Sleep studies

Sleep studies are tests that monitor you while you sleep to find out if you have any breathing difficulties. These studies may be performed at a hospital, a freestanding sleep center, or at home.

	With CIC	Without CIC
Sleep studies	Deductible, then 100%	Deductible, then 80%

▶ **Notify AIM** – Your provider must notify AIM Specialty Health at least seven days before services start.

Speech therapy

Expenses for the diagnosis and treatment of speech, hearing and language disorders (speech-language pathology services) are covered when provided by a licensed speech-language pathologist or audiologist and when the services are provided in a hospital, clinic or private office.

	With CIC	Without CIC
Speech therapy	100%, up to a limit of 20 visits each plan year	80%, up to a limit of 20 visits each plan year

Covered speech therapy services include:

- ❑ Assessment of and remedial services for speech defects caused by physical disorders
- ❑ Speech rehabilitation, including physiotherapy, following laryngectomy

✕ **Restrictions:**

- The following services are not covered:
  - Cognitive therapy or rehabilitation
  - Language therapy for learning disabilities such as dyslexia
  - Services that a school system is obligated to provide under Massachusetts Special Education Law (M.G.L. c. 71(b)) known as Chapter 766, or under similar laws in other states
  - Services provided in a school-based setting
  - Voice therapy

Surgery

The surgery benefit covers payment to a surgical provider for operative services including care before, during and after surgery. A covered **surgical procedure** can be any of the following:

- ❑ A cutting procedure
- ❑ The suturing of a wound
- ❑ The treatment of a fracture
- ❑ The reduction of a dislocation
- ❑ Radiation therapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor
- ❑ Electrocauterization
- ❑ Diagnostic and therapeutic endoscopic procedures
- ❑ Interventional radiologic procedure
- ❑ Injection treatment of hemorrhoids and varicose veins
- ❑ An operation by means of laser beam
- ❑ Any other procedures classified as surgery by the American Medical Association (AMA), such as skin tag or wart removal

	With CIC	Without CIC
Inpatient surgery You'll also owe the inpatient hospital copay (page 50)	Deductible, then 100%	Deductible, then 80%
Outpatient surgery at a hospital-owned location	$250 quarterly copay, then deductible, then 100%	$250 quarterly copay, then deductible, then 80%
Outpatient surgery at a non-hospital-owned location Such as a doctor's office or an ambulatory surgery center	Deductible, then 100%	Deductible, then 80%

Charges for the following services qualify as covered surgical charges:

1. Medically necessary surgical procedures when performed on an inpatient or outpatient basis (hospital, physician's office or ambulatory surgery center)
2. Services of one **assistant surgeon** when:
   - ❑ Medically necessary
   - ❑ The assistant surgeon is a physician trained in a surgical specialty related to the procedure and is not a fellow, resident or intern in training, and
   - ❑ The assistant surgeon serves as the first assistant surgeon to the primary surgeon during a surgical procedure
3. Reconstructive breast surgery for all stages of mastectomy, including:
   - ❑ All stages of breast reconstruction
   - ❑ Reconstruction of the other breast to produce a symmetrical appearance
   - ❑ Coverage for prosthetics and treatment of physical complications, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury, including the application of appropriate copays, deductibles and coinsurance amounts. Several states have enacted laws that require coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state's law.

Restrictions:

- Coverage for **reconstructive and restorative surgery** – defined as surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by either a congenital anomaly or a previous surgical procedure or disease – is limited to the following:
  - Correction of a functional physical impairment due to previous surgery or disease
  - Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five years of the removal surgery.
  - Correction of a congenital birth defect that causes functional impairment for a minor dependent child
- Cosmetic procedures / services are not covered, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury.
- Assistant surgeon services are limited, as follows:
  - Only one assistant surgeon per procedure is covered; second and third assistants are not covered.
  - Assistant surgeons who are not physicians – such as nurse practitioners, nurses and technicians – are not covered.
  - Interns, residents and fellows are not covered as assistant surgeons.
  - Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.

Notify UniCare – Notify UniCare Customer Service at least seven days before having any of the surgical procedures listed on pages 18-19.

Tobacco cessation counseling

Counseling for tobacco dependence / smoking cessation is covered up to a limit of 300 minutes each plan year. It is reimbursed up to the Plan's allowed amount.

	With CIC	Without CIC
Tobacco cessation counseling	100%, up to 300 minutes each plan year	100%, up to 300 minutes each plan year

A **tobacco cessation program** is a program that focuses on behavior modification while reducing the amount smoked over a number of weeks, until the quit, or cut-off, date. Tobacco cessation counseling can occur in a face-to-face setting or over the telephone, either individually or in a group.

Counseling may be provided by physicians, nurse practitioners, physician assistants, nurse-midwives, registered nurses and tobacco cessation counselors. **Tobacco cessation counselors** are non-physician providers who have completed at least eight hours of instruction in tobacco cessation from an accredited institute of higher learning. They must work under the supervision of a physician.

Tobacco cessation counseling can be billed directly to UniCare. However, if your provider is unable to bill the Plan directly, or does not accept insurance, you can submit your claim yourself. Download a claim form at unicarestateplan.com or call UniCare Customer Service at 800-442-9300 to ask for the form.

Nicotine replacement products are available at no cost through the prescription drug plan, but you must have a prescription. See Part 2 of this handbook for details.

✕ Restrictions:

- Tobacco cessation counseling is limited to 300 minutes each plan year.

Transplants

Benefits are payable – subject to any deductible, copays, coinsurance and benefit limits – for necessary medical and surgical expenses incurred for the transplanting of a human organ. To get the highest benefit, see "Quality Centers and Designated Hospitals for transplants" later in this section.

	With CIC	Without CIC
At a Quality Center or Designated Hospital for transplants	$275 quarterly copay, then deductible, then 100%	$300 quarterly copay, then deductible, then 100%
At another hospital	$275 quarterly copay, then deductible, then 80%	$300 quarterly copay, then deductible, then 80%

A case manager is available to support you and your family before the transplant procedure and throughout the recovery period. The case manager will:

- ❑ Review your ongoing needs
- ❑ Help to coordinate services while you are awaiting a transplant
- ❑ Help you and your family optimize Plan benefits
- ❑ Maintain communication with the transplant team
- ❑ Facilitate transportation and housing arrangements, if needed
- ❑ Facilitate discharge planning alternatives
- ❑ Help to coordinate home care plans, if appropriate
- ❑ Explore alternative funding or other resources in cases where there is need but benefits under the Plan are limited

☎ **Notify UniCare** – Notify UniCare Customer Service when your doctor recommends a transplant evaluation, but no less than 21 calendar days before transplant-related services are scheduled to start.

- ❑ Call UniCare Customer Service at 800-442-9300 and ask to speak with a case manager. (See page 84 for more information about case management.)
- ❑ You do not need to notify UniCare for cornea transplants.

Human organ donor services

Benefits are payable – subject to any deductible, copays, coinsurance and benefit limits – for necessary expenses incurred for delivery of a human organ (any part of the human body, excluding blood and blood plasma) and medical expenses incurred by a person in direct connection with the donation of an organ.

Benefits are payable for any person who donates a human organ to a person covered under the Plan, whether or not the donor is a member of the Plan.

The Plan also covers expenses for human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish the suitability of a bone marrow transplant donor. Such expenses consist of testing for A, B or DR antigens, or any combination thereof, consistent with the guidelines, criteria, rules and regulations established by the Massachusetts Department of Public Health.

Quality Centers and Designated Hospitals for transplants

UniCare has designated certain hospitals as Quality Centers and Designated Hospitals for organ transplants. These hospitals were chosen for their specialized programs, experience, reputation and ability to provide high-quality transplant care. The purpose of this program is to facilitate the provision of timely, cost-effective, quality services to eligible members.

Transplants at Quality Centers and Designated Hospitals are covered at 100% after the copay and deductible. Transplants at other hospitals are covered at 80% after the copay and deductible. Although you have the freedom to choose any health care provider for these procedures, your coverage is highest when you use one of these Quality Centers or Designated Hospitals.

Travel clinics

The Plan covers office visits at travel clinics. Immunizations and their administration are also covered.

	With CIC	Without CIC
Travel clinic office visits	100%	100%
Immunizations at travel clinics	100%	100%

Restrictions:

- There is no coverage for blood tests (titers) to determine if you need an immunization, unless you are pregnant. See restriction #38 on page 71.

Wigs

Wigs are covered when hair loss is due to cancer or leukemia treatment.

	With CIC	Without CIC
Wigs	80%	80%

Restrictions:

- There is no coverage if hair loss is due to anything other than cancer or leukemia treatment.

Schedule of preventive care services

The Plan covers preventive or routine level office visits, physical examinations and other related preventive services listed in Table 6. Covered preventive services include those services recommended by the U.S. Preventive Services Task Force as part of the Patient Protection and Affordable Care Act (PPACA), the health care reform legislation that was passed in March 2010. Preventive exams are covered according to the schedule issued by Massachusetts Health Quality Partners.

Benefits for the services listed here are covered at 100% subject to the gender, age and frequency guidelines indicated.

Preventive services do not generally include services intended to treat an existing illness, injury, or condition. Benefits will be determined based on how the provider submits the bill. Claims must be submitted with the appropriate diagnosis and procedure code in order to be paid at the 100% benefit level. If during your preventive services visit you receive services to treat an existing illness, injury or condition, you may be required to pay a copay, deductible and/or coinsurance for those covered services.

Please note that the preventive health care services, screenings, tests and vaccines listed are not recommended for everyone. You and your health care provider should decide what care is most appropriate.

Table 6. Preventive Care Schedule

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
Abdominal aortic aneurysm screening	■				65-75	One time
Alcohol misuse screening and counseling	■	■	■			Covered as a component of your preventive exam
Anemia screening	■	■	■	■		
Aspirin preventive medication	■	■				Subject to the Plan's pharmacy benefit
Bacteriuria screening			■			
Blood pressure screening	■	■	■			Covered as a component of your preventive exam
Breast cancer screening (mammogram)		■			35 and 40 and older	Once between the ages of 35 and 40; yearly after age 40
Breast cancer preventive medications discussion		■	■			Covered as a component of your preventive exam
☎ BRCA risk assessment and genetic counseling / testing		■	■			One time
Breastfeeding counseling		■	■			
Cervical cancer screening (Pap smear)		■	■	■		Every 12 months

Table 6. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
Chlamydia screening		■	■	■		
Cholesterol abnormalities screening	■	■	■			Every 12 months
Colorectal cancer screening (Screenings include colonoscopies, fecal occult blood testing, and other related services and tests) Colonoscopies for members under 50 are covered under limited circumstances (see #15 on page 69) ☎ Virtual colonoscopies require pre-service review	■	■			50 and older	Every 5 years (60 months) Every 12 months for fecal occult blood test
Depression screening	■	■	■	■		Covered as a component of your preventive exam
Diabetes screening (Type 2 and gestational)	■	■	■			
Diet and physical activity counseling in primary care to promote healthy diet, in adults at high risk for cardiovascular disease (see #52 on page 72)	■	■	■			Covered as a component of your preventive exam
Fall prevention for at-risk community-dwelling adults (Vitamin D counseling and/or physical therapy)	■	■			65 and over	Counseling is covered as a component of your preventive exam
Fluoride varnish for children, starting at the age of primary tooth eruption				■	Up to age 5	
Folic acid supplementation		■	■			Subject to the Plan's pharmacy benefit
Gonorrhea screening		■	■			Every 12 months
Gonorrhea prophylactic medication (newborns)				■		
Gynecological examination		■				Every 12 months
Hearing loss screening (newborns)				■		
Hepatitis B screening	■	■	■	■		
Hepatitis C screening	■	■	■	■		

Table 6. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
HIV screening	■	■	■	■		
Human papillomavirus (HPV) DNA test		■	■		30 and older	Every 3 years for women with normal cytology results
Hypothyroidism screening (newborns)				■		
Immunizations	■	■	■	■		
Intimate partner violence screening (women of childbearing age)		■	■			Covered as a component of your preventive exam
Iron deficiency anemia prevention (at risk 6- to 12-month-old babies)				■		
Lead screening (children)				■		
► Lung cancer screening (CT scan) for adults who have smoked	■	■			55-80 years	Every 12 months
Obesity screening	■	■	■	■		Covered as a component of your preventive exam
Osteoporosis screening (bone density testing)		■	■		40 and older	Every 2 years
Phenylketonuria (PKU) screening (newborn)				■		
Preeclampsia prevention (aspirin) counseling			■			Covered as a component of your preventive exam
Preventive exams for children up to age 19				■		▪ Four examinations, including hearing screening, while the newborn is in the hospital. ▪ Five visits until 6 months of age; then ▪ Every two months until 18 months of age; then ▪ Every three months from 18 months of age until 3 years of age; then ▪ Every 12 months from 3 years of age until 19 years of age.
Preventive exams for adults age 19 and over	■	■				Every 12 months

Table 6. Preventive Care Schedule *(continued)*

Preventive Service	Men	Women	Pregnant Women	Children	Age	Frequency
Prostate cancer screening (digital rectal exam and PSA test)	■				50 and older	▪ Digital exam – Covered as a component of your preventive exam ▪ PSA test – Every 12 months
Rh incompatibility screening			■			
Sexually transmitted infections counseling	■	■	■	■		Covered as a component of your preventive exam
Sickle cell disease screening (newborns)				■		
Skin cancer behavioral counseling	■	■	■	■	10-24 years	Covered as a component of your preventive exam
Syphilis screening	■	■	■	■		
Tobacco use counseling and interventions	■	■	■	■		▪ Counseling – Covered as a component of your preventive exam ▪ Drugs and deterrents – Subject to the Plan's pharmacy benefit
Visual impairment screening	■	■	■	■		Covered as a component of your preventive exam
Additional covered preventive screening laboratory tests for adults: ▪ Hemoglobin ▪ Urinalysis ▪ Chemistry profile, including: – Complete blood count (CBC) – Glucose – Blood urea nitrogen (BUN) – Creatinine transferase alanine amino (SGPT) – Transferase asparate amino (SGOT) – Thyroid stimulating hormone (TSH)	■	■	■			When performed as a component of your preventive exam

4: Coverage that is excluded or limited

This chapter lists services and supplies that have no coverage or have limited coverage under the Plan.

Important! Charges that are excluded by the Plan don't count toward your member costs or your out-of-pocket limits.

1. **Acne-related services**, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin, are not covered. Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.
2. **Acupuncture / acupuncture-related services** are not covered.
3. **Ambulance services** are limited to transportation in the case of an emergency. Coverage for ground, air and sea ambulance services does not include:
   - ❑ Transportation to a specified or preferred facility, if there is a nearer facility equipped to treat the condition. The nearest facility may be in another state or country, depending on where the emergency occurred.
   - ❑ Ambulance calls for transportation that is refused
   - ❑ Transportation to medical appointments, such as dialysis treatment
   - ❑ Transportation in chair cars or vans
4. **Anesthesia** for behavioral health services is only covered for electroconvulsive therapy (ECT). Note that other charges associated with ECT are covered under the behavioral health benefits described in Part 3 (pages 123-147).
5. **Arch supports** are not covered.
6. **Assistant surgeon services** are limited, as follows:
   - ❑ Only one assistant surgeon per procedure is covered; second and third assistants are not covered.
   - ❑ Assistant surgeons who are not physicians – such as nurse practitioners, nurses and technicians – are not covered.
   - ❑ Interns, residents and fellows are not covered as assistant surgeons.
   - ❑ Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.
7. **Athletic trainers** – Services provided by athletic trainers, including physical therapy, are not covered.
8. **Beds** – There is no coverage for non-hospital beds or orthopedic mattresses.
9. **Behavioral health conditions** – With the exception of primary care visits associated with a behavioral health diagnosis, there is no coverage for the diagnosis, treatment or management of mental health/substance use disorder conditions by medical (non-behavioral health) providers. See Part 3 (pages 123-147) for coverage details when these services are provided by behavioral health providers.

10. **Blood donations** – There is no coverage for blood that you, or someone on your behalf, has donated for your use.
11. **Blood pressure cuffs (sphygmomanometers)** are not covered.
12. **Chair cars / vans** – Transportation in chair cars or vans is not covered.
13. **Clinical trials for treatments other than cancer** – Any clinical research trial other than a qualified clinical trial for the treatment of cancer (page 35) is not covered.
14. **Cognitive rehabilitation or therapy** is defined as treatment to restore function or minimize effects of cognitive deficits including, but not limited to, those related to thinking, learning and memory. There is no coverage for cognitive rehabilitation or therapy.
15. **Colonoscopies** – Screening colonoscopies for people under 50 are covered as a preventive service only under limited circumstances, based on clinical review of family and personal history.
16. **Computer-assisted communications devices** are not covered.
17. **Cosmetic services** are defined as services performed mainly for the purpose of improving appearance. These services do not restore bodily function or correct functional impairment. There is no coverage for cosmetic procedures or services, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury. Cosmetic services are not covered even if they are intended to improve a member's emotional outlook or treat a member's mental health condition.
18. **Custodial care** is defined as a level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function. There is no coverage for custodial care.
19. **Dental care** – Because the Plan is not a dental plan, benefits are limited. See "Dental services" on page 37 for more information.
20. **Dentures, dental prosthetics and related surgery** are not covered.
21. **Driving evaluations** are not covered.
22. **Drugs**
    a) **Drugs prescribed off-label** – Drugs not used in accordance with indications approved by the Food and Drug Administration (off-label use of a prescription drug) are not covered unless the use meets the Plan's definition of medical necessity, or the drug is specifically designated as covered by the Plan.
    b) **Over-the-counter drugs** are not covered. Some over-the-counter drugs, such as tobacco cessation products, are covered by the prescription drug plan when you have a prescription.
    c) **Non-oncology infused drugs** require prior review and are dispensed by the prescription drug plan (Part 2 of this handbook).
    d) **Specialty drugs** – Self- or office-administered specialty drugs are covered and dispensed under the prescription drug plan (Part 2 of this handbook). Specialty drugs (specialty medications) are defined as certain pharmaceutical and/or biotech or biological drugs (including "biosimilars" or "follow-on biologics") which are used in the management of chronic or genetic disease. Specialty drugs include, but are not limited to, injectables, infused, inhaled or oral medications, or otherwise require special handling.

23. **Duplicate services** – Duplicate or redundant services are not covered. A service or supply is considered redundant when the same service or supply is being provided or being used, at the same time, to treat the condition for which it is ordered.
24. **Ear molds** are not covered, except when needed for hearing aids for members age 21 and under.
25. **EKG (electrocardiogram)** done solely for the purpose of screening or prevention is not covered.
26. **Email consultations** are not covered (also see restriction #72).
27. **Enteral therapy** is prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Prescription and nonprescription enteral formulas are covered only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.
28. **Experimental or investigational services or supplies** – There is no coverage for a service or supply that is determined by the Plan to be experimental or investigational; that is, through the use of objective methods and study over a long enough period of time to be able to assess outcomes, the evidence is inadequate or lacking as to its effectiveness. The fact that a physician ordered it, or that this treatment has been tried after others have failed, does not make it medically necessary.
29. **Eyeglasses and contact lenses** are only covered within six months after an eye injury or cataract surgery. Coverage applies to the initial lenses only. There is no coverage for deluxe frames or specialty lenses such as progressive or transitional lenses, tinted lenses, anti-reflective coating or polycarbonate lenses.
30. **Family members / household residents** – A service or supply provided by you, a member of your family or by any person who resides in your home is not covered. Your family consists of you, your spouse and children, as well as brothers, sisters and parents of both you and your spouse.
31. **Fitness reimbursement** – The following restrictions apply to the fitness reimbursement benefit:
    - ❑ Although any family member may have the fitness membership, the reimbursement is a one-time payment each plan year and is made to the plan enrollee only.
    - ❑ Fitness clubs are limited to health clubs or gyms that offer cardio and strength-training machines, and other programs for improved physical fitness. Martial arts centers, gymnastics centers, country clubs, beach clubs, sports teams and leagues, and tennis clubs are not considered fitness clubs.
    - ❑ There is no fitness reimbursement benefit for personal trainers, sports coaches, yoga classes or exercise machines.
32. **Free or no-cost services** – There is no coverage for any medical service or supply for which there would have been no charge in the absence of medical insurance.

33. **Government programs** – There is no coverage for any service or supply furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies, except for the following:
    - ❑ A program established for its civilian employees
    - ❑ Medicare (Title XVIII of the Social Security Act)
    - ❑ Medicaid (any state medical assistance program under Title XIX of the Social Security Act)
    - ❑ A program of hospice care
34. **Group occupational therapy** and **group physical therapy** are not covered.
35. **Hearing aid batteries** are not covered.
36. **Hippotherapy** (therapeutic or rehabilitative horseback riding) is not covered.
37. **Home construction** or remodeling to accommodate a medical condition, such as the installation of a wheelchair ramp, is not covered.
38. **Immunization titers** are lab tests which are performed to determine if a person has had a vaccination. They are covered for pregnant women only.
39. **Incontinence supplies** are not covered.
40. **Infertility treatment**
    - a) **Experimental infertility treatments** are not covered.
    - b) **In vitro fertilization** and other associated infertility procedures, with the exception of artificial insemination, are limited to five attempts.
    - c) **Reversal of voluntary sterilization** is not covered.
    - d) **Sperm, egg and/or inseminated egg procurement** and processing, and banking of sperm or inseminated eggs, are covered only for the treatment of infertility.
    - e) **Surrogates** – Medical services in connection with the use of a gestational carrier or surrogate, including in vitro fertilization, are not covered.
41. **Intraocular lenses (IOLs)** – Monofocal intraocular lenses (IOLs) implanted in the eye after the removal of cataracts are covered when you have cataract surgery. However, there is no coverage for presbyopia-correcting IOLs (IOLs that restore vision in a range of distances). Multifocal IOLs and accommodating IOLs are both types of presbyopia-correcting IOLs and are also not covered.
42. **Language therapy** for learning disabilities such as dyslexia is not covered.
43. **Lift / riser chairs** are not covered.
44. **Long-term maintenance care and long-term therapy** are not covered.
45. **Manipulative therapy**
    - a) Certain manipulative therapies and physical therapy services are not covered. These include, but are not limited to: acupuncture, aerobic exercise, craniosacral therapy, diathermy, infrared therapy, kinetic therapy, massage therapy, microwave therapy, paraffin treatment, rolfing therapy, Shiatsu, sports conditioning, ultraviolet therapy, weight training, and therapies performed in a group setting.
    - b) Manipulative therapy provided by a chiropractor is considered chiropractic care, not physical therapy.

46. **Massage therapy** and any other services provided by a massage therapist or neuromuscular therapist are not covered.
47. **Medical necessity** – There is no coverage for any service or supply that is not medically necessary for the care and treatment of an injury, disease or pregnancy. The only exceptions to this exclusion are:
    - ❑ Routine care of a newborn child provided by a hospital during a hospital stay that starts with birth and while the child's mother is confined in the same hospital
    - ❑ Covered preventive care provided by a hospital or physician (page 56)
    - ❑ A service or supply that qualifies as a covered hospice care service (page 47)
48. **Medical orders** – All covered services and supplies require a medical order from a physician. There is no coverage for any service or supply that has not been recommended and approved by a physician.
49. **Missed appointments** – Charges for missed appointments are not covered.
50. **Molding helmets** and adjustable bands intended to mold the shape of the cranium are not covered.
51. **Non-covered services and associated services** – There is no coverage for facility fees, anesthesia or other services required for the performance of a service that is not covered by the Plan. Non-covered services include those for which there is no benefit and those that the Plan has determined to be not medically necessary.
52. **Nutritional counseling** – Services or counseling must be performed by a registered dietician and are only covered for:
    - ❑ Adults at high risk for cardiovascular disease (limited to three visits a year)
    - ❑ Children under 18 with cleft lip / palate (page 35)
    - ❑ Members with certain eating disorders (see Part 3 of this handbook)
    - ❑ Members with diabetes (page 37)
53. **Oral nutritional supplements** – There is no coverage for nutritional supplements that are administered by mouth, including:
    - ❑ Dietary and food supplements that are administered orally and related supplies
    - ❑ Nutritional supplements to boost caloric or protein intake, including sport shakes, puddings and electrolyte supplements
54. **Orthodontic treatment**, including treatment done in preparation for surgery, is not covered.
55. **Orthopedic / corrective shoes** are not covered, except when the shoe attaches directly to a brace.
56. **Orthopedic mattresses** are not covered.
57. **Orthotics** – There is no coverage for test or temporary orthotics, video tape gait analysis, diagnostic scanning, or arch supports.
58. **Oxygen equipment for travel** – There is no coverage for oxygen equipment required for use on an airplane or other means of travel.

59. **Personal comfort items** – There is no coverage for personal comfort items related to activities of daily living that could be purchased without a prescription. These items include, but are not limited to: air conditioners, air purifiers, bed pans, blood pressure monitors, commodes, corrective shoes, dehumidifiers, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, telephones, televisions, whirlpools or spas and other similar items.
60. **Private duty nursing services** in an acute care hospital or any other inpatient facility are not covered.
61. **Programs with multiple services** – Programs that provide multiple services but that bill at a single, non-itemized rate (for example, a daily fee for a full-day rehab program) are not covered. Itemized bills are always required.
62. **Religious facilities** – Services received at non-medical religious facilities are not covered.
63. **Respite care** is limited to a total of five days. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home.
64. **Routine screenings** are not covered except according to the preventive care schedule (pages 64-67).
65. **Schools** – There is no coverage for any services or treatments required under law to be provided by the school system for a child.
66. **Sensory integration therapy** is not covered.
67. **Serious preventable adverse events** – Costs associated with serious preventable adverse health care events are not covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts providers are not permitted to bill members for designated serious reportable health care events.

    For more information on this policy and a list of these events, visit unicarestateplan.com.
68. **Shipping costs**, such as the cost of shipping eggs or sperm between fertility clinics, are not covered.
69. **Stairway lifts** and **stair ramps** are not covered.
70. **Storage for blood / bodily fluids** – Storage of autologous blood donations or other bodily fluids or specimens is not covered, except when done in conjunction with use in a scheduled procedure that is covered.
71. **Surface electromyography (SEMG)** is not covered.
72. **Telehealth** – Covered telehealth services are limited to the delivery of services through the use of interactive audio-visual, or other interactive electronic media, for the purpose of diagnosis, consultation, and/or treatment of a patient in a location separate from the provider. There is no coverage for audio-only telephone consultations, email consultations, or services obtained from websites or from providers over the Internet.
73. **Telephone consultations** are not covered (also see restriction #72).
74. **Thermal therapy** – Any type of hot or cold thermal therapy device is not covered.

75. **Third parties** – There is no coverage for any medical supply or service (such as a court-ordered test or an insurance physical) that is required by a third party but is not otherwise medically necessary. Other examples of a third party are an employer, an insurance company, a school, a court or a sober living facility.

76. **TMJ (temporomandibular joint disorder)** – Treatment of TMJ disorder is limited to the initial diagnostic examination, initial testing and medically necessary surgery. TMJ disorder is a syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.

77. **Tobacco cessation counseling** is limited to 300 minutes each plan year. Counseling is also covered as part of your preventive exam.

78. **Transportation** to medical appointments, including to dialysis treatment, is not covered.

79. **Travel time** – There is no coverage for travel time to or from appointments for medical care.

80. **Vision care** – There is no coverage for vision care, including:
    - ❑ Orthoptics for correction of vision
    - ❑ Radial keratotomy and related laser surgeries to correct myopia
    - ❑ Other surgeries, services or supplies to detect or correct refractive errors, such as astigmatism, myopia, hyperopia and presbyopia

81. **Vision therapy** is not covered.

82. **Voice therapy** is not covered.

83. **Web and Internet-based services** – There is no coverage for services obtained from websites or from providers over the Internet (also see restriction #72).

84. **Weight loss**
    a) **Physician services for weight loss treatment** are limited to members whose body mass index (BMI) is 40 or more (morbidly obese) while under the care of a physician. Any such treatment is subject to periodic review.
    b) **Residential inpatient weight loss programs** are not covered.
    c) **Membership fees and food items** used to participate in a commercial weight loss program are not covered.

85. **Wigs** are covered only for the replacement of hair loss resulting from treatment of any form of cancer or leukemia.

86. **Worker's compensation** – There is no coverage for any service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a workers' compensation law or similar law. **Occupational injury or disease** is an injury or disease that arises out of and in the course of employment for wage or profit.

87. **Worksite evaluations** performed by a physical therapist to evaluate a member's ability to return to work are not covered.

5: About your plan and coverage

How to use your plan wisely

Be sure to look over this section to learn what you can do to get the highest level of benefits for your medical care. Keeping these tips in mind will help you avoid paying more than you need to for your care.

For a description of the different kinds of providers talked about in this section, see "Types of health care providers" on pages 76-78.

When you get health care in Massachusetts

- ❑ **See Tier 1 or Tier 2 specialists** – Tier 1 and Tier 2 specialists have demonstrated quality and/or cost efficiency in their practices. Your copays are lower when you use Tier 1 or Tier 2 specialists. See pages 78-79 for more information about physician tiering.
- ❑ **Use UniCare preferred vendors** – Services from preferred vendors are covered at 100%. When you use non-preferred vendors, services are covered at 80%, so you'll owe 20% coinsurance. And, outside of Massachusetts, non-preferred vendors may balance bill you for charges over the Plan's allowed amounts. (Note that your deductible may also apply, no matter which type of vendor you use.)

  In this handbook, the **checkmark** ✓ identifies services that have preferred vendors. For more information, see "About preferred vendors" on page 27.
- ❑ **Have outpatient surgery at a non-hospital-owned location** – You don't have an outpatient surgery copay when you have your surgery at a non-hospital-owned ambulatory surgery center or doctor's office.
- ❑ **Take advantage of non-hospital-owned walk-in clinics for non-emergency care** – You'll have a $20 copay if you go to a walk-in clinic, like an urgent care center, instead of a hospital emergency room. Just make sure the clinic isn't owned by a hospital. Hospital-owned urgent care centers often bill your visits as emergency room treatment, which means you would owe the $100 emergency room copay.

To avoid being balance billed for care outside Massachusetts

- ❑ **If you live outside Massachusetts, use network providers** – Always use providers in your home state that are in the UniCare network. Network providers won't balance bill you for charges over the Plan's allowed amount.
- ❑ **If you need urgent care while traveling, use a Travel Access provider** – No matter where you live, always use Travel Access providers if you need urgent care when you aren't in your home state. (If you are visiting Massachusetts, however, you can use any provider.)
- ❑ **Make sure your out-of-state dependent uses Travel Access providers** – Covered dependents who live in a state other than your home state (or Massachusetts) should use Travel Access providers when they need urgent care. However, to avoid being balance billed, they must get all their non-urgent care – including annual checkups – in your home state.

Behavioral health services – For mental health and substance use disorder services, you must use a provider in the Beacon Health Options network to avoid getting balance billed. These benefits are administered by Beacon, not by UniCare. See Part 3 (pages 123-147) for information about these benefits.

Provide notice about certain medical services

- ❑ Be sure to provide notice if you will be having any of the services or procedures listed in Table 1 (pages 16-19). Your benefit may be reduced by up to $500 if you don't provide enough notice. However, if you're outside the continental United States (that is, outside the contiguous 48 states), you aren't required to provide notice.

  In this handbook, the **telephone** ☎ marks services you need to tell UniCare about and the **triangle** ▶ marks services your provider needs to tell AIM about. For details, see "When you must provide notice about your care" on pages 14-19.

Types of health care providers

This handbook talks about many different providers of medical care and services. Here's a brief look at what to know about the different kinds of providers.

To find health care providers, go to the *Members* page at unicarestateplan.com and choose *Find a doctor*. You can also call UniCare Customer Service at 800-442-9300 for help.

Primary care providers (PCPs)

We strongly encourage all UniCare members to choose a **primary care provider**, or **PCP**. Having a PCP means working with a provider who is familiar with you and your health care needs. Your PCP can help you understand and coordinate care you get from other providers, such as specialists, who may not know you as well.

A PCP can be a nurse practitioner, physician assistant or physician whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.

Important! Some specialists may also provide primary care. If so, they will be considered specialists when we determine their tier and copay assignments. This means you will pay the specialist office visit copay, whether you see the specialist for a primary care or specialty care visit.

Patient-Centered Primary Care practices

Many PCPs in Massachusetts belong to practices that are in UniCare's Patient-Centered Primary Care program, part of the GIC's Centered Care Initiative.

The Centered Care Initiative seeks to improve health care coordination and quality while reducing costs. PCPs play a critical role in helping their patients get the right care at the right place with the right provider. The central idea is to coordinate health care services around the needs of you – the patient. Because health care is so expensive, Centered Care also seeks to engage providers and health plans on managing these dollars more efficiently.

The **Patient-Centered Primary Care** program is UniCare's application of the Centered Care initiative. Patient-Centered Primary Care practices are Massachusetts primary care practices that participate in the program.

You can find more information about the Patient-Centered Primary Care program at unicarestateplan.com.

Specialists

Specialists, also called **specialty care providers**, are physicians, nurse practitioners and physician assistants who focus on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

As a UniCare member, you don't need a referral to see a specialist. When you do seek specialty care, you'll have lower office visit copays when you use Tier 1 and Tier 2 specialists in Massachusetts.

Members who live outside of Massachusetts can see specialists in their home state for a $60 copay.

Hospitals

As a Basic member, you can use any hospital at the same level of coverage. If you live outside of Massachusetts, be sure to use hospitals in your home state that are in the UniCare provider network because they won't balance bill you for charges above the Plan's allowed amount (page 26).

Urgent care centers

Urgent care centers are groups of providers who treat conditions that should be checked right away, but that aren't as severe as emergencies. They can often do X-rays, lab tests and stitches. Using an independent urgent care center instead of a hospital emergency room saves you money. Be aware, however, that facilities owned and operated by hospitals are hospital sites, not urgent care centers, and often bill your visit as an emergency room visit.

Preferred vendors

Preferred vendors are providers who have contracted with UniCare to accept the Plan's allowed amounts for one or more of the following services:

- ❑ Durable medical equipment (DME)
- ❑ Home health care
- ❑ Home infusion therapy
- ❑ Medical / diabetes supplies

Services from preferred vendors are covered at 100% of the allowed amount. Non-preferred vendors are covered at 80% and you will owe the 20% coinsurance. If you live outside of Massachusetts, non-preferred vendors can balance bill you for charges over the allowed amount. (Note that your deductible may also apply, no matter which type of vendor you use.)

In this handbook, the **checkmark** ✓ identifies services that have preferred vendors.

Specialized health facilities

Specialized health facilities are independent, stand-alone centers that provide a variety of medical services. They include:

- ❑ Ambulatory surgery centers
- ❑ Dialysis centers
- ❑ Fertility clinics
- ❑ Imaging centers
- ❑ Sleep study centers

Services at specialized health facilities often cost less than at hospitals, and you may save on your member costs too. For example, you won't owe a copay if you have outpatient surgery at a non-hospital-owned ambulatory surgery center.

Be aware, however, that facilities owned and operated by hospitals are hospital sites, not specialized health facilities. The presence of a hospital name indicates that the site is part of a hospital, not a stand-alone specialized health facility.

Network providers and Travel Access providers

Network providers are non-Massachusetts providers of medical care and services – such as doctors, hospitals, and health facilities – who have contracted with UniCare to accept the Plan's allowed amount. If you live outside of Massachusetts, always use network providers in your home state so you won't be balance billed for charges over the allowed amount. Network providers won't balance bill you for covered services.

No matter where you live, you can get care from any provider in Massachusetts. State law prohibits Massachusetts providers from balance billing UniCare members.

Non-network providers in other states may balance bill you, however. If you need urgent care when you're not in your home state and not in Massachusetts, use Travel Access providers. **Travel Access providers** are network providers that are available when you need urgent care while traveling outside your home state. When you use these providers, you will not be balance billed for your care.

Behavioral health services – For mental health and substance use disorder services, you must use a provider in the Beacon Health Options network to avoid getting balance billed. These benefits are administered by Beacon, not by UniCare. See Part 3 (pages 123-147) for information about these benefits.

How to find providers

To find health care providers, go to the *Members* page at unicarestateplan.com and choose *Find a doctor*. You'll find options that let you search for:

- ❑ Providers in Massachusetts
- ❑ PCPs participating in the Patient-Centered Primary Care program
- ❑ Urgent care centers
- ❑ Preferred vendors
- ❑ Specialized health facilities
- ❑ Travel Access providers and other providers in the UniCare network

You can also call UniCare Customer Service at 800-442-9300 for help.

About physician tiering

To help you make more informed choices about the specialists (specialty care physicians) you see, the GIC's Clinical Performance Improvement (CPI) Initiative includes a physician tiering program for specialists. **Physician tiering** is a program implemented by the Plan whereby Massachusetts specialists are assigned to different tiers based on an extensive evaluation of both their quality and cost efficiency.

Under this program, we assign individual Massachusetts specialists to tiers based on how they score on quality and/or cost efficiency compared to the other physicians in the same specialty. We use this comparison to place specialists into one of three tiers, as described below. The names of the tiers have been assigned by the GIC for use uniformly across all of its participating health plans.

***Tier 1 (Excellent)

Tier 1 specialists have met or exceeded the quality threshold we established for their specialty. Based on our measures, they also showed that they are the most cost efficient compared to their peers in the same medical specialty. Tier 1 is designed to acknowledge the performance of these physicians in terms of both quality and/or cost-efficiency measures, as determined by the available claims data and the standards we use.

**Tier 2 (Good)

Tier 2 specialists are those who have met or exceeded the quality assessment threshold established for their specialty. However, based on our measures, they have not performed as well on cost efficiency as those physicians in Tier 1.

*Tier 3 (Standard)

Tier 3 specialists are those who did not meet our quality threshold established for their specialty, or our measures indicated that they were the least cost efficient, or both.

> **Note:** Sometimes we don't have enough quality data to evaluate specialists. In that case, we evaluate the specialists based only on their cost-efficiency data. If they meet our cost-efficiency criteria, they are assigned to one of the three tiers based only on their cost-efficiency scores.

Also, for a variety of reasons, certain specialists don't have enough data available to allow us to assess either their quality or cost efficiency according to our procedures. In our provider listing, these specialists are placed in the category of **Not Tiered/Insufficient Data (NT/ID)**. You can see these specialists for a $60 copay.

Primary care providers (PCPs) are included in our physician listing, but they aren't tiered. You pay a $20 copay for all primary care visits. PCPs include physicians, nurse practitioners and physician assistants whose specialty is family medicine, general medicine, pediatrics, geriatrics or internal medicine.

You can find a detailed explanation about the assignment of doctors to tiers and about the methods used to determine the quality and cost-efficiency scores of the physicians at unicarestateplan.com. You can also call UniCare Customer Service at 800-442-9300 to request materials.

We assign specialists to different tiers using data based on the claims that physicians submit and our tiering methodology. We know that using claims data has some limitations. We also know that there are other ways to evaluate physicians for their quality or cost efficiency. When you choose your physicians, you may rely on other information that we cannot get through claims data. You may also rely on your own views about what quality means. Although we use a standardized approach that we have developed to evaluate quality and cost efficiency, we understand that our members need to choose physicians who are appropriate for them, and you are not prevented from doing so by our tiering program.

How to find a specialist's tier

To find out which tier a specialist is in, go to the *Members* page at unicarestateplan.com and choose *Physician listing*. You can also call UniCare Customer Service at 800-442-9300 for help.

How UniCare reimburses providers

The Plan routinely reimburses providers on a fee-for-service basis. As various models of health care reform are put in place, as anticipated by legislation in Massachusetts, the Plan may engage certain providers in shared savings and loss arrangements where providers receive additional payments for meeting quality and cost targets. Explanations of this type of provider payment will be available on the Plan website and on request as they are put in place. In this Plan, providers may discuss the way they are compensated with you.

How to submit a claim

To receive benefits from the Plan, a claim must be filed for each service. Most hospitals, physicians and other health care providers will submit claims for you. If your provider files claims on your behalf, the provider will be paid directly. If you submit your own claim, you must provide written proof of the claim that includes:

- ❑ Diagnosis
- ❑ Date of service
- ❑ Amount of charge
- ❑ Name, address and type of provider
- ❑ Provider tax ID number, if known
- ❑ Name of enrollee
- ❑ Enrollee's ID number
- ❑ Name of patient
- ❑ Description of each service or purchase
- ❑ Other insurance information, if applicable
- ❑ Accident information, if applicable
- ❑ Proof of payment, if applicable

If the proof of payment you get from a provider contains information in a foreign language, please provide UniCare with a translation, if possible.

UniCare's claim form may be used to submit written proof of a claim. Original bills or paid receipts from providers will also be accepted as long as the information described above is included.

You can print or request a claim form from unicarestateplan.com, or call UniCare Customer Service at 800-442-9300 to request a form.

Claims for prescription drug or behavioral health services – These claims must be submitted directly to the administrator of those services. For prescription drug claims, see Part 2 (pages 107-121). For mental health, substance use disorder and EAP claims, see Part 3 (pages 123-147).

Deadlines for filing claims

Written proof of a claim must be submitted to UniCare within two years of the date of service. Claims submitted after two years will be accepted for review only if you show that the person submitting the claim was mentally or physically incapable of providing written proof of the claim in the required amount of time.

Checking your claims for billing accuracy

The Bill Checker program

The goal of the Bill Checker program is to detect overpayments that are the result of billing errors that only you may recognize. The Plan encourages you to review all of your medical bills for accuracy, just as you might do with your utility bills. If you find a billing error and get a corrected bill from your provider, you will share in any actual savings realized by the Plan.

What you need to do

You must ask the provider to send you an itemized bill for the services you received. As soon as possible, review this bill for any charges that indicate treatment, services or supplies that you did not receive. Check items such as:

- ❑ Did you receive the therapy described on the bill?
- ❑ Did you receive X-rays as indicated on your bill?
- ❑ Are there duplicate charges on the same bill?
- ❑ Have you been charged for more services than you received?
- ❑ Did you receive the laboratory services described on the bill?
- ❑ Does the room charge reflect the correct number of days?
- ❑ Were you charged for the correct type of room?

If you find an error

If you find an error, contact the provider or the provider's billing office and report the exact charges you are questioning. Request an explanation of any discrepancies and ask for a revised itemized bill showing any adjustments.

How to get your share of the savings

To receive your share of the savings, you must send copies of both the original and revised bills to the Plan, along with the completed Bill Checker form. A Bill Checker form can be found in Appendix B.

You can also download this form from unicarestateplan.com.

Be sure to include the enrollee's name and identification number on the Bill Checker form. The Plan will review the two bills and, if a billing error is confirmed, you will receive 25% of any savings that the Plan realizes. All reimbursements are subject to applicable state and federal income taxes.

Provider bills eligible under the program

All bills that UniCare provides the primary benefits for are eligible under the Bill Checker program. Members who have Medicare as their primary coverage cannot use Bill Checker. This program may not apply to certain inpatient bills paid under the Diagnosis Related Group (DRG) methodology. Bills for prescription drugs and behavioral health services are also excluded because UniCare does not administer those benefits.

About claim reviews

UniCare routinely reviews submitted claims to evaluate the accuracy of billing information. We may request written documentation such as operative notes, procedure notes, office notes, pathology reports and X-ray reports from your provider.

Reviews for fraud and other inappropriate activity

To detect fraud, waste, abuse and other inappropriate activity, UniCare reviews claims both before and after payment. If a claim is denied as a result of this review, the provider – whether in Massachusetts or elsewhere – may bill the member. A claim under this review may be denied if the provider fails to submit medical records associated with the claim.

In cases of suspected claim abuse or fraud, UniCare may require that the person whose disease, injury or pregnancy is the basis of the claim be examined by a physician selected by the Plan. This examination must be approved by the Executive Director of the GIC, and will be performed at no expense to you.

Deadlines on bringing legal action

You cannot bring suit or legal action to recover benefits for charges incurred while covered under the Plan any earlier than 60 days, or any later than three years, after UniCare receives complete written proof of the claim. However, if the state where you lived at the time of the alleged loss has a longer time limit, the limit is extended to be consistent with that state's law.

Right of reimbursement

If you or your dependents receive payments from a third party for an injury or disease that UniCare previously paid claims for, UniCare will have a lien on any money you receive. This lien applies to any money you or your covered dependents receive from, among others, the person or entity responsible for the injury or disease, his or her insurers, or your own auto insurance carrier, including uninsured or underinsured motorist coverage.

You and your dependents will not have to reimburse UniCare for any more than the amount UniCare paid in benefits.

You or your dependents must execute and deliver any documents required by UniCare or its designee, and do whatever is necessary to help UniCare attempt to recover benefits it paid on behalf of you or your dependents.

About your privacy rights

The GIC's *Notice of Privacy Practices* appears in Appendix A. This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information. The notice also explains your rights as well as the GIC's legal duties and privacy practices.

About your appeal rights

You have the right to appeal an adverse benefit determination made by the Plan within 180 days of being notified of the determination. See Appendix D for instructions on how to file an appeal.

> **Appeals for prescription drug or behavioral health services** – These appeals must be filed with the administrator of those services. For prescription drug appeals, see Part 2 (pages 107-121). For mental health, substance use disorder and EAP appeals, see Part 3 (pages 123-147).

How medical services get reviewed

As explained in "When you must provide notice about your care" on page 14, either UniCare or AIM Specialty Health must be notified if you are scheduled to have any of the services listed in Table 1 (pages 16-19). These services are reviewed to make sure they are eligible for benefits. Pre-service reviews are a standard practice of most health plans. These reviews help ensure that benefits are paid appropriately for services that meet the Plan's definition of medical necessity.

> The clinical criteria used for these reviews are developed with input from actively practicing physicians, and in accordance with the standards adopted by the national accreditation organizations. The criteria are regularly updated as new treatments, applications and technologies become generally-accepted professional medical practice.

A UniCare nurse may speak with your health care providers to determine if a service is eligible for benefits. The nurse will also review your clinical situation and circumstances.

If the nurse is unable to make a determination, the Plan will invite your provider to speak with one of UniCare's physician advisors to discuss the proposed treatment and/or the treatment setting. Once a decision is made, UniCare will contact your provider directly, and you will be notified in writing.

Asking for reconsideration if coverage is denied

If your request has been denied either before or while you are getting health care services, you or your doctor may ask for reconsideration. Your request can be made by phone or in writing. The reconsideration process gives your doctor the opportunity to speak with another clinical peer reviewer who was not involved in the original denial.

For an immediate reconsideration, the UniCare Customer Service Center must get the request and all supporting information within three business days of when you received the denial. The reconsideration will take place within two business days after all necessary supporting documents have been received. The decision is then communicated in writing to you and your doctor.

If the denial is upheld, you can appeal the decision. See Appendix D for instructions on how to file an appeal.

Getting support for serious medical issues

If you are dealing with serious, complex medical issues, one of UniCare's case managers can help. **Case managers** are registered nurses who can support you and your family when you're faced with a serious medical problem like a stroke, cancer, spinal cord injury, or any another condition that requires multiple medical services. Case managers will:

- ❑ Help you and your family cope with the stress associated with an illness or injury by facilitating discussions about health care planning
- ❑ Support the coordination of services among multiple providers
- ❑ Work with your providers to support your present and future health care needs
- ❑ Let you know about available resources that may be helpful
- ❑ Work with the behavioral health plan to help coordinate services and maximize benefits, if your condition requires both medical and behavioral health services
- ❑ Explore alternative funding or other resources in cases where there is need but benefits under the Plan are limited
- ❑ Promote education, wellness, self-help and prevention programs to help manage chronic disease conditions
- ❑ Encourage the development of a care plan to ease the transition from hospital to home

If you would like help dealing with a serious medical situation, call UniCare at 800-442-9300 and ask to speak with a case manager.

6: About enrollment and membership

This chapter describes the enrollment process for you and your eligible dependents; when coverage starts and ends; and continuing coverage when eligibility status changes.

Free or low-cost health coverage for children and families

If you are eligible for health coverage from your employer but are unable to afford the premiums, your state may have a premium assistance program to help pay for coverage. For more information, see Appendix C, "Federal and State Mandates."

Application for coverage

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC.

You must enroll dependents when they become eligible. Newborns (including grandchildren, if they are eligible dependents of your covered dependents) must be enrolled within 60 days of birth, and adopted children within 60 days of placement in the home. Spouses must be enrolled within 60 days of the marriage.

You must complete an enrollment form to enroll or add dependents. Additional documentation may be required, as follows:

- ❑ **Newborns:** copy of hospital announcement letter or the child's certified birth certificate
- ❑ **Adopted children:** photocopy of proof of placement letter or adoption
- ❑ **Foster children ages 19-26:** photocopy of proof of placement letter or court order
- ❑ **Spouses:** copy of certified marriage certificate

When coverage begins

Coverage under the Plan starts as follows:

For new employees

New employee coverage begins on the first day of the month following 60 calendar days from the first date of employment, or two calendar months, whichever comes first.

For persons applying during an annual enrollment period

Coverage begins each year on July 1.

For spouses and dependents

Coverage begins on the later of:

1. The date your own coverage begins, or
2. The date that the GIC has determined your spouse or dependent is eligible

For surviving spouses

Upon application, you will be notified by the GIC of the date your coverage begins.

When coverage ends for enrollees

Your coverage ends on the earliest of:

1. The end of the month covered by your last contribution toward the cost of coverage
2. The end of the month in which you cease to be eligible for coverage
3. The date of death
4. The date the surviving spouse remarries, or
5. The date the Plan terminates

When coverage ends for dependents

A dependent's coverage ends on the earliest of:

1. The date your coverage under the Plan ends
2. The end of the month covered by your last contribution toward the cost of coverage
3. The date you become ineligible to have a spouse or dependents covered
4. The end of the month in which the dependent ceases to qualify as a dependent
5. The date the dependent child, who was permanently and totally disabled by age 19, marries
6. The date the covered divorced spouse remarries (or the date the enrollee marries)
7. The date of the spouse or dependent's death, or
8. The date the Plan terminates

Duplicate coverage

No person can be covered (1) as both an employee, retiree or surviving spouse, and a dependent, or (2) as a dependent of more than one covered person (employee, retiree, spouse or surviving spouse).

Special enrollment condition

If you declined to enroll your spouse or dependents as a new hire, your spouse or dependents may only be enrolled within 60 days of a qualifying status change event or during the GIC's annual enrollment period. To obtain GIC enrollment and change forms, active employees should contact the GIC Coordinator at their workplace, and retirees should contact the GIC. Enrollment and change forms are also available at **mass.gov/gic**.

Continuing coverage upon termination of employment

Coverage may be continued if eligibility status changes due to termination of employment, involuntary layoff, reduction of work hours, or retirement. For information on options for continuation of coverage, visit the GIC's website at mass.gov/gic.

Continuing health coverage for survivors

Surviving spouses of covered employees or retirees, and/or their eligible dependent children, may be able to continue coverage. Surviving spouse coverage ends upon remarriage. Orphan coverage is also available for some surviving dependents. For more information on eligibility for survivors and orphans, contact the GIC.

To continue coverage, you must submit an enrollment form to the GIC to continue coverage within 30 days of the covered employee or retiree's death. You must also make the required contribution toward the cost of the coverage.

Coverage will end on the earliest of:

1. The end of the month in which the survivor dies
2. The end of the month covered by your last contribution payment for coverage
3. The date the coverage ends
4. The date the Plan terminates
5. For dependents: the end of the month in which the dependent would otherwise cease to qualify as a dependent, or
6. The date the survivor remarries

Option to continue coverage for dependents age 26 and over

A dependent child who reaches age 26 is no longer eligible for coverage under this Plan. Dependents age 26 or over who are full-time students at accredited educational institutions may continue to be covered. However, you must pay 100% of the individual premium. The student must also submit an application to the GIC no later than 30 days after his or her 26th birthday. If this application is submitted late, your dependent may apply during the GIC's annual enrollment period. Full-time students age 26 and over are not eligible for continued coverage if there has been a two-year break in their GIC coverage.

Option to continue coverage after a change in marital status

Your former spouse will not cease to qualify as a dependent under the Plan solely because a judgment of divorce or separate support is granted. (For the purposes of this provision, "judgment" means only a judgment of absolute divorce or of separate support.) Massachusetts law presumes that he or she continues to qualify as a dependent, unless the divorce judgment states otherwise.

If you get divorced, you must notify the GIC within 60 days and send the GIC a copy of the following sections of your divorce decree: Divorce Absolute Date, Signature Page, and Health Insurance Provisions. **If you or your former spouse remarries, you must also notify the GIC. If you fail to report a divorce or remarriage, the Plan and the GIC have the right to seek recovery of health claims paid or premiums owed for your former spouse.**

Under M.G.L. Ch. 32A as amended and the GIC's regulations, your former spouse will no longer qualify as a dependent after the earliest of these dates:

1. The end of the period in which the judgment states he or she must remain eligible for coverage
2. The end of the month covered by the last contribution toward the cost of the coverage
3. The date he or she remarries
4. The date you remarry. If your former spouse is covered as a dependent on your remarriage date, and the divorce judgment gives him or her the right to continue coverage, coverage will be available at full premium cost (as determined by the GIC) under a divorced spouse rider. Alternatively, your former spouse may enroll in COBRA coverage.

Group health continuation coverage under COBRA

This notice explains COBRA and what you need to do to protect your right to receive it. You will receive a COBRA notice and application if the Group Insurance Commission (GIC) is informed that your current GIC coverage is ending due either to (1) end of employment; (2) reduction in hours of employment; (3) death of employee/retiree; (4) divorce or legal separation; or (5) loss of dependent child status. This COBRA notice contains important information about your right to temporarily continue your health care coverage in the GIC's health plan through a federal law known as COBRA. If you elect to continue your coverage, COBRA coverage will begin on the first day of the month immediately after your current GIC coverage ends.

You must complete and return the GIC COBRA Election Form no later than 60 days after your group coverage ends. You may send it to the GIC's Public Information Unit at P.O. Box 8747, Boston, MA 02114 or hand deliver it to the GIC at 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage.

What is COBRA coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

Who is eligible for COBRA coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts or a municipality covered by the GIC's health benefits program, you have the right to choose COBRA coverage if:

- ❑ You lose your group health coverage because your hours of employment are reduced; or
- ❑ Your employment ends for reasons other than gross misconduct.

If you are the spouse of an employee covered by the GIC's health benefits program, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- ❑ Your spouse dies;
- ❑ Your spouse's employment with the Commonwealth or participating municipality ends for any reason other than gross misconduct or his/her hours of employment are reduced; or
- ❑ You and your spouse legally separate or divorce.

If you have dependent children who are covered by the GIC's health benefits program, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- ❑ The employee-parent dies;
- ❑ The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- ❑ The parents legally separate or divorce; or
- ❑ The dependent ceases to be a dependent child under GIC eligibility rules

How long does COBRA coverage last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce – occurs during the 18 months of COBRA coverage. **You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.** Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage.**

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- ❑ The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- ❑ You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- ❑ You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- ❑ The Commonwealth of Massachusetts or your municipal employer no longer provides group health coverage to any of its employees; or
- ❑ Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud).

The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

How and when do I elect COBRA coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after your GIC coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA coverage cost?

Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

How and when do I pay for COBRA coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. Alternately, you may purchase health insurance through the Commonwealth's Health Connector Authority or through the Health Insurance Marketplace in other states. The GIC has no involvement in conversion programs or the Health Connector programs. You pay the premium to the plan sponsor for the coverage. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

Your COBRA coverage responsibilities

- ❑ **You must inform the GIC of any address changes to preserve your COBRA rights;**
- ❑ **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- ❑ **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- ❑ **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- ❑ **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The insured dies;
  - The insured becomes legally separated or divorced;
  - The insured or insured's former spouse remarries;
  - A covered child ceases to be a dependent under GIC eligibility rules;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. *To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at the Group Insurance Commission, P.O. Box 8747, Boston, MA 02114.*

If you have questions about COBRA coverage, contact the GIC's Public Information Unit at 617-727-2301, extension 1, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 866-444-3272 or **dol.gov/ebsa**. For more information about health insurance options available through a Health Insurance Marketplace, visit **healthcare.gov** or, in Massachusetts, visit **mahealthconnector.org**.

Conversion to non-group health coverage

Under certain circumstances, a person whose Plan coverage is ending has the option to convert to non-group health coverage arranged for by UniCare. Conversion to non-group health coverage may offer less comprehensive benefits and higher member cost-sharing than either COBRA coverage or plans offered under the Health Insurance Marketplaces in many states. Contact UniCare for details of converted coverage.

A certificate for non-group health coverage can be obtained if:

1. Employment for coverage purposes ends for any reason other than retirement; or
2. Status changes occur for someone who is not eligible for continued coverage under the Plan (including those members who have exhausted their COBRA benefits).

A certificate of coverage is also available to the following persons whose coverage under the Plan ceases:

1. Your spouse and/or your dependents, if their coverage ceases because of your death
2. Your child, covering only that child, if that child ceases to be covered under the Plan solely because the child no longer qualifies as your dependent
3. Your spouse and/or dependents, if their coverage ceases because of a change in marital status

You cannot obtain a certificate of coverage if you are otherwise eligible under the Plan, or if your coverage terminated for failure to make a required payment. No certificate of coverage will be issued in a state or country where UniCare is not licensed to issue it.

The certificate of coverage will cover you and your dependents who cease to be covered under the Plan because your health coverage ends. It will also cover any of your dependent children born within 31 days after such coverage ends.

The following rules apply to the issuance of the certificate of coverage:

1. Written application and payment for your first premium must be submitted within 31 days after your coverage under the Plan ends.
2. The certificate of coverage is governed by the rules for converted coverage UniCare is using at the time your written application is received. Such rules include: the form of the certificate; its benefits; the individuals covered; the premium payable, and all other terms and conditions of such certificate.
3. If the certificate will be delivered to a state outside of Massachusetts, it may be issued on the form offered by that state.
4. The certificate of coverage will become effective the day after your coverage under the Plan ends.
5. No evidence of insurability will be required.

Coordination of Benefits (COB)

It is common for family members to be covered by more than one health care plan. This happens, for example, when spouses or partners have family coverage through both of their employers or former employers. When you or your dependents are covered by more than one health plan, one plan is identified as the primary plan for coordination of benefits (COB). Any other plan is then the secondary plan. The goal of COB is to determine how much each plan should pay when you have a claim, and to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Definition of plan

For the purposes of COB, the term **plan** is defined as any plan that provides medical or dental care coverage. Examples include, but are not limited to, group or blanket coverage; group practice or other group prepayment coverage, including hospital or medical services coverage; labor-management trusteed plans; union welfare plans; employer organization plans; employee benefit organization plans; automobile no-fault coverage; and coverage under a governmental plan, or coverage required or provided by law, including any legally required, no-fault motor vehicle liability insurance. (This does not include a state plan under Medicaid or any plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.)

The term **plan** does not include school-accident type plans or coverage that you purchased on a non-group basis.

Determining the order of coverage

If the UniCare State Indemnity Plan is the primary plan, benefit payments will be made as if the secondary plan or plans did not exist. A secondary plan may reduce its benefits if payments were made by the UniCare State Indemnity Plan.

If another plan is primary, benefit payments under the UniCare State Indemnity Plan are determined in the following manner:

a) The Plan determines its **covered expenses** – that is, what the Plan would pay in the absence of other insurance; then

b) The Plan subtracts the **primary plan's benefits** – benefits paid by the other plan, or the reasonable cash value of any benefits in the form of services – from the covered expenses in (a) above; and then

c) The Plan pays the difference, if any, between (a) and (b).

The following are the rules used by the UniCare State Indemnity Plan (and most other plans) to determine which plan is the primary plan and which plan is the secondary plan:

1. The plan without a COB provision is primary.
2. The plan that covers the person as an employee, member, or retiree (that is, other than as a dependent) is primary, and the plan that covers the person as a dependent is secondary.
3. The order of coverage for a dependent child who is covered under both parents' plans is determined by the **birthday rule**, as follows:

   a) The primary plan is the plan of the parent whose birthday falls first in the calendar year, or

   b) If both parents have the same birthday (month and day only), the primary plan is the plan that has covered a parent for the longest period of time

   However, if the other plan has a rule based on the gender of the parent, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

4. The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, follows any applicable court decree.

   If there is no such decree determining which parent is financially responsible for the child's health care expenses, coverage is determined as follows:

   a) First, the plan covering the parent with custody of the child (the custodial parent)
   b) Second, the plan covering the custodial parent's spouse, if applicable
   c) Third, the plan covering the non-custodial parent
   d) Fourth, the plan covering the non-custodial parent's spouse, if applicable

5. According to the **active before retiree rule**, the plan that covers a person as an active employee is primary, and the plan that covers that same person as a retiree is secondary. This applies both to that person and his or her dependents.

   However, if the other plan's rule is based on length of coverage, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

If none of the above rules can be applied, the plan that has covered the person for a longer period of time is primary, and the plan that has covered that same person for the shorter period of time is secondary.

Right to receive and release information

In order to fulfill the terms of this COB provision or any similar provision:

- ❑ A claimant must provide the Plan with all necessary information
- ❑ The Plan may obtain from or release information to any other person or entity as necessary

Facility of payment

A payment made under another plan may include an amount that should have been paid by the UniCare State Indemnity Plan. If it does, the Plan may pay that amount to the organization that made the payment, and treat it as a benefit payable under the UniCare State Indemnity Plan. The UniCare State Indemnity Plan will not have to pay that amount again.

Right of recovery

If the UniCare State Indemnity Plan pays more than it should have under the COB provision, the Plan may recover the excess from one or more of the following:

- ❑ The persons it has paid or for whom it has paid
- ❑ The other insurance company or companies
- ❑ Other organizations

COB for persons enrolled in Medicare

The benefits for an enrollee and his or her dependents simultaneously covered by the UniCare State Indemnity Plan and Medicare Part A and/or Part B will be determined as follows:

1. Expenses payable under Medicare will be considered for payment only to the extent that they are covered under the Plan and/or Medicare.
2. In calculating benefits for expenses incurred, the total amount of those expenses will first be reduced by the amount of the actual Medicare benefits paid for those expenses, if any.
3. UniCare State Indemnity Plan benefits will then be applied to any remaining balance of those expenses.

Special provisions applicable to employees and dependents who are 65 or older and eligible for Medicare

Active employees and their dependents age 65 or over who are eligible for medical coverage under the Plan may continue that coverage, regardless of their eligibility for or participation in Medicare.

Medical coverage primary to Medicare coverage for the disabled

Employees or dependents under age 65 who are covered under the Plan and are entitled to Medicare disability for reasons other than end-stage renal disease (ESRD) may continue their coverage under the UniCare State Indemnity Plan, regardless of their eligibility for or participation in Medicare.

Health coverage primary to Medicare coverage for covered persons who have end-stage renal disease

For all covered persons with end-stage renal disease (ESRD), coverage under the UniCare State Indemnity Plan will be primary to Medicare during the Medicare ESRD waiting period and the Medicare ESRD coordination period.

End-stage renal disease (ESRD) means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life.

Medicare ESRD waiting period is generally the first three months after starting dialysis. You are not entitled to Medicare until after the three-month waiting period. This waiting period can be waived or shortened if a member participates in a self-dialysis training program or is scheduled for an early kidney transplant.

Medicare ESRD coordination period is 30 months long and occurs after the ESRD waiting period. The ESRD coordination period begins on the date that Medicare became effective **or would have become effective on the basis of ESRD**.

During that 30-month period, the UniCare State Indemnity Plan is the primary payer and Medicare is the secondary payer, for the purpose of the coordination of benefits (COB). After the 30 months, Medicare becomes the primary payer and the Plan becomes the secondary payer. At this point, you must change health plans. Contact the GIC at:

Group Insurance Commission
P.O. Box 8747
Boston, MA 02114-0998

7: How to get more information

Who to contact (and for what)

For questions about your medical plan	
UniCare State Indemnity Plan Customer Service Center P.O. Box 9016 Andover, MA 01810-0916 800-442-9300 (toll free) TDD: 800-322-9161 contact.us@anthem.com unicarestateplan.com	▪ What your benefits are for a particular medical service or procedure ▪ The status of (or a question about) a medical claim ▪ How to find a doctor, hospital or other medical provider ▪ Information that appears in Part 1, the "Your Medical Plan" section of this handbook
For questions about your prescription drug plan	
CVS Caremark 877-876-7214 (toll free) TDD: 800-238-0756 caremark.com	▪ What your benefit is for a prescription drug ▪ The status of (or a question about) a prescription drug claim ▪ Where to get prescriptions filled ▪ Which drugs are covered ▪ Information that appears in Part 2, the "Prescription Drug Plan" section of this handbook
For questions about your behavioral health plan	
Beacon Health Options 855-750-8980 (toll free) TDD: 866-727-9441 beaconhealthoptions.com/gic	▪ What your benefits are for mental health services ▪ What your benefits are for substance use disorder services ▪ What your benefits are for the Enrollee Assistance Program (EAP) ▪ The status of (or a question about) a mental health, substance use disorder or EAP claim ▪ Information that appears in Part 3, the "Behavioral Health Plan" section of this handbook
For general health questions after hours (not about plan benefits or coverage)	
24/7 NurseLine 800-424-8814 (toll free) Plan code: 1002	▪ How to prepare for an upcoming medical procedure ▪ What side effects are possible from your medication ▪ Whether to go to an urgent care center or call your doctor ▪ See page 99 for more information about the 24/7 NurseLine

For other questions, such as questions about premiums or participation in any Group Insurance Commission (GIC) programs, please see your GIC coordinator or contact the GIC.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Contacting the UniCare Customer Service Center

The UniCare Customer Service Center in Andover, Massachusetts, is where UniCare administers services; processes claims; and provides customer service, pre-service review and case management for your medical benefits (that is, the benefits described in Part 1 of this handbook).

> **Prescription drug benefits** are administered by CVS Caremark (Part 2 of this handbook). **Behavioral health benefits** are administered by Beacon Health Options (Part 3 of this handbook). These benefits are not administered at the UniCare Customer Service Center.

To reach the UniCare Customer Service Center, call 800-442-9300 (toll free). Representatives are available Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. (Eastern time) to answer questions you or your family may have about your medical coverage.

You can use our automated phone line (800-442-9300) to get information about your claims at any time. You can also set up a user account that will let you access your claims online (page 98).

When you call the UniCare Customer Service Center, you will speak with either a customer service representative or a nurse reviewer, depending on the nature of your call.

Customer service representatives are benefits specialists who can answer questions about:

- ❑ Claim status
- ❑ Notification requirements
- ❑ Covered services
- ❑ Preferred vendors and specialized health facilities
- ❑ Plan benefits
- ❑ Resources on the unicarestateplan.com website

Nurse reviewers are registered nurses who can help you coordinate your Plan benefits based on your health care needs. The nurse reviewer can:

- ❑ Provide information about the pre-service review process, case management, and Quality Centers and Designated Hospitals for transplants
- ❑ Answer questions about coverage for hospital stays and certain outpatient benefits
- ❑ Speak with you and your provider about covered and non-covered services to help you get care and coverage in the most appropriate health care setting, and let you know what services are covered
- ❑ Assist with optimizing benefits for covered services after you are discharged from the hospital

Using the unicarestateplan.com website

Throughout this handbook, the **computer** lets you know about information and resources available at **unicarestateplan.com**. The website is a valuable resource that has the most up-to-date information about the Plan.

The subsections below describe how to use website resources and tools to:

- Set up an online account so you can check your claim status and monitor your health care spending
- Find health care providers, both in Massachusetts and elsewhere
- Compare costs and earn cash rewards at Massachusetts medical facilities
- View, download or order plan materials, forms and documents

The website also provides information on a variety of topics, such as:

- Health and wellness
- Health care quality initiatives
- Changes in health care today
- Advance care planning
- Discounts on health-related products and services

Setting up a user account

To check your claims and health care spending online, you must register as a UniCare member at the **unicare.com** website. From the *Members* page of unicarestateplan.com, select *Check your claims* and follow the instructions to reach the home page of unicare.com. Then, click on *Register Now* and follow the instructions to set up your user account.

Register by creating a user ID and password to protect the privacy of your information. Dependents age 18 or older can access their individual claims information by establishing their own user IDs and passwords.

Finding providers

To find health care providers, choose *Find a doctor* from the unicarestateplan.com *Members* page. You'll find a variety of options that let you search for:

- Providers in Massachusetts
- Network providers in other states
- Travel access providers
- Preferred vendors
- Specialized health facilities
- Urgent care centers
- Retail medical clinics

The provider listings also indicate which Massachusetts PCPs participate in UniCare's Patient-Centered Primary Care program, as well as the tier assignments for specialists in Massachusetts.

Comparing costs and earning cash rewards at Massachusetts facilities

Different medical facilities can charge different prices for the exact same test or procedure. The **Vitals SmartShopper™** program lets you compare your costs for common procedures at Massachusetts hospitals and other facilities. In some cases, you can get a cash reward when you choose a cost-effective provider. SmartShopper lets you:

- ❑ Compare the costs of many common tests and procedures at different medical facilities in Massachusetts. You'll see the overall cost and your maximum out-of-pocket costs (copays, deductible and coinsurance).
- ❑ Qualify for a cash reward of $25 to $500 if you choose a cost-effective option for some of these tests and procedures.
- ❑ Compare the cost of office visits with primary and specialty care providers in Massachusetts.

Using SmartShopper does not change your plan benefits or your member costs (copays, deductible and coinsurance).

To get to the SmartShopper website, go the *Members* page and select *Compare your costs*. You can also call SmartShopper at 800-824-9127 to find out if the procedure or service you're getting is eligible for a cash reward.

☞ **Important!** To qualify for a cash reward, you must use SmartShopper before you have the test or procedure.

Getting documents, forms and other materials

You can download this handbook and other plan materials in PDF format at unicarestateplan.com. We recommend doing this (if you have access to a computer), because it is almost always easier and faster to find information by searching in an electronic document such as a PDF. In a PDF, simply type CTRL-F, then type a word or phrase to search for in the *Find* box.

To download a copy of this handbook, go to the *Members* page and choose *Member Handbooks*. To download other materials, choose *Forms and Documents* from the *Members* menu.

To order printed items (like claim forms), choose *Request Plan Materials* from the *Members* menu.

Using the 24/7 NurseLine

The 24/7 NurseLine provides toll-free access to extensive health information at any time. The 24/7 NurseLine is an educational resource. If you have specific issues about your health or your treatment, you should always consult your doctor.

When you call the 24/7 NurseLine, you'll speak with registered nurses who can discuss your concerns, address your questions about procedures or symptoms, and help you prepare for a doctor's visit. They can also discuss your medications and any potential side effects. The 24/7 NurseLine can also refer you to local, state and national self-help agencies.

To speak with a nurse, call the 24/7 NurseLine toll free at 800-424-8814. You will need to provide the following plan code: 1002.

How to ask for a claim review

If you have questions about a claim, you can ask to have the claim reviewed. Contact us in any of the ways listed below. Be sure to provide us with any additional information about your claim, if any. We will notify you of the result of the investigation and the final determination.

- ❑ **Call** UniCare Customer Service at 800-442-9300
- ❑ **Email** UniCare Customer Service at contact.us@anthem.com
- ❑ **Mail** your written request to:

  UniCare State Indemnity Plan
  Claims Department
  P.O. Box 9016
  Andover, MA 01810-0916

How to check on your claims

You can check the status of your claims 24 hours a day, seven days a week in the following two ways:

- ❑ Call 800-442-9300 and select the option to access our automated information line.
- ❑ Go to unicarestateplan.com and set up a user account (page 98).

How to ask to have medical information released

The GIC's policies for releasing and requesting medical information comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, see the GIC's *Notice of Privacy Practices* in Appendix A.

8: Definitions

Allowed amount (page 25) – The maximum amount on which payment is based for covered health care services. If a non-Massachusetts provider charges more than the allowed amount, you may have to pay the difference. (Also see "balance billing.")

Ambulatory surgery center – An independent, stand-alone facility licensed to provide same-day (outpatient) surgical, diagnostic and medical services that require dedicated operating rooms and post-operative recovery rooms. These facilities are independent centers, not hospital-run facilities located in a hospital or elsewhere. The presence of a hospital name indicates that the site is a hospital facility, not an ambulatory surgery center.

Appeal (Appendix D) – A request for UniCare to review a decision or a grievance.

Balance billing (pages 26-27) – When a provider bills you for the difference between the provider's charge and the amount paid by the Plan (the allowed amount). For example, if the provider's charge is $100 and the allowed amount is $70, the provider may balance bill you for the remaining $30. Under Massachusetts General Law, Chapter 32A: Section 20, Massachusetts providers are prohibited from balance billing you.

Behavioral health services (pages 123-147) – Mental health, substance use disorder and Enrollee Assistance Program (EAP) services. The benefits for these services are administered by Beacon Health Options and are described in Part 3 of this handbook.

CIC (Comprehensive Insurance Coverage) – Plan participants can select CIC (comprehensive) or non-CIC (non-comprehensive) insurance coverage. CIC increases the benefits for most covered services to 100%, subject to any applicable copays and deductible. Members without CIC have higher copays and receive only 80% coverage for some services.

Coinsurance (page 25) – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance *plus* any copays and deductible that may apply.

Copay / copayment (pages 22-24) – A fixed amount (for example, $20) you pay for a covered health care service, usually when you get the service. The dollar amount of the copay depends on the service it applies to. Not all services have copays.

Cosmetic services (page 69) – Services performed mainly to improve appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered.

Custodial care (page 69) – A level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

Deductible (page 21) – A set amount you must pay toward covered health care services before the Plan starts to pay. For example, if your deductible is $300, the Plan won't pay anything until you've paid that amount toward services that are subject to the deductible. The deductible doesn't apply to all services.

Dependent

1. The employee's or retiree's spouse or a divorced spouse who is eligible for dependent coverage pursuant to Massachusetts General Laws Chapter 32A as amended
2. A GIC-eligible child, stepchild, adoptive child or eligible foster child of the member, or of the member's spouse, until the end of the month following the dependent's 26th birthday
3. A GIC-eligible unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC
4. A dependent of a dependent, if the primary dependent is either a full-time student or an IRS dependent, or has been an IRS dependent within the past two years

If you have questions about coverage for someone whose relationship to you is not listed above, contact the GIC.

Elective – A medical service or procedure is elective if you can schedule it in advance, choose where to have it done, or both. If you choose to have a procedure outside your home state, you may be balance billed.

Enrollee – An employee, retiree or survivor who is covered by the GIC's health benefits program and enrolled in the UniCare State Indemnity Plan. (Enrollees are the same as subscribers.)

Experimental or investigational procedure – A service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

Grievance – A complaint that you communicate to the Plan.

Hospital (acute care hospital) – An institution that meets all of the following conditions:

1. Is operated pursuant to law for the provision of medical care
2. Provides continuous 24-hour-a-day nursing care
3. Has facilities for diagnosis
4. Has facilities for major surgery
5. Provides acute medical / surgical care or acute rehabilitation care
6. Is licensed as an acute hospital
7. Has an average length of stay of less than 25 days

The following facilities are not considered hospitals:

- ❑ Rest homes
- ❑ Nursing homes
- ❑ Convalescent homes
- ❑ Places for custodial care
- ❑ Homes for the elderly

Also see the definition for "Other inpatient facilities."

Injury – Accidental bodily injury caused by something external (outside of your body).

Medical supplies or equipment – Disposable items that physicians prescribe as medically necessary to treat a disease or injury. Such items include surgical dressings, splints and braces.

Medically necessary – With respect to care under the Plan, medically necessary treatment will meet at least the following standards:

1. Is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for your illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-V or its equivalent ICD-10CM)
2. Is reasonably expected to improve or palliate your illness, condition or level of functioning
3. Is safe and effective according to nationally-accepted standard clinical evidence that is generally recognized by medical professionals and peer-reviewed publications
4. Is the most appropriate and cost-effective level of care that can safely be provided for your diagnosed condition
5. Is based on scientific evidence for services and interventions that are not in widespread use

Important! The fact that a doctor may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device or drug does not, in and of itself, make it medically necessary or make the charge a covered expense under the Plan, even if it has not been listed as an exclusion.

Member – An enrollee or his/her dependent who is covered by the Plan.

Network – The facilities, providers and suppliers that the Plan has contracted with to provide health care services.

Non-preferred vendor (page 27) – A vendor who does not have a contract with the Plan to provide certain services or equipment including, but not limited to, durable medical equipment and medical supplies. You pay more member costs when you use non-preferred vendors.

Nursing home – An institution that:

1. Provides inpatient skilled care and related services, and
2. Is licensed in any jurisdiction requiring such licensing, but
3. Does not qualify as a skilled nursing facility (SNF) as defined by Medicare

A facility or part of a facility does not qualify as a nursing home if it is used primarily for:

- ❑ Rest
- ❑ Mental health or substance use disorder treatment
- ❑ Custodial care or educational care

Other inpatient facilities (page 52) – Includes the following facilities:

- ❑ Chronic disease hospitals / facilities
- ❑ Long-term care hospitals / facilities
- ❑ Skilled nursing facilities
- ❑ Sub-acute care hospitals / facilities
- ❑ Transitional care hospitals / facilities
- ❑ Any inpatient facility with an average length of stay greater than 25 days

Out-of-pocket limit (page 25) – The most you could pay during the plan year for your member costs (deductible, copays, coinsurance). Once you reach your out-of-pocket limit, the Plan starts to pay 100% of the allowed amount. There are three separate out-of-pocket limits, each of which applies to different services:

- ❑ Out-of-pocket limit for all medical services and in-network behavioral health services
- ❑ Out-of-pocket limit for out-of-network behavioral health services
- ❑ Out-of-pocket limit for prescription drugs

These limits don't include premiums, balance-billed charges, or costs for health care that the Plan doesn't cover.

Physician – Includes the following health care providers acting within the scope of their licenses or certifications:

- ❑ Certified nurse midwife
- ❑ Chiropractor
- ❑ Dentist
- ❑ Nurse practitioner
- ❑ Optometrist
- ❑ Physician
- ❑ Physician assistant
- ❑ Podiatrist

Preferred vendors (page 27) – Providers that the Plan contracts with to provide certain services or equipment including, but not limited to, durable medical equipment (DME), medical supplies, and home health care. You receive these services at a higher benefit level when you use preferred vendors.

Rehabilitation services – Health care services that help a person keep, get back or improve skills and functioning for daily living that were lost or impaired due to illness, injury or disability. These services may include physical therapy, occupational therapy, and speech-language pathology in a variety of inpatient and/or outpatient settings.

Skilled care – Medical services that can only be provided by a registered or certified professional health care provider.

Skilled nursing facility (SNF) – An institution that meets all of the following conditions:

1. Operates pursuant to law
2. Is licensed or accredited as a skilled nursing facility (if the laws of its jurisdiction provide for the licensing or the accreditation of a skilled nursing facility)
3. Is approved as a skilled nursing facility for payment of Medicare benefits, or is qualified to receive such approval, if requested
4. Primarily engages in providing room and board and skilled care under the supervision of a physician
5. Provides continuous 24-hour-a-day skilled care by or under the supervision of a registered nurse (RN)
6. Maintains a daily medical record for each patient

A facility or part of a facility does not qualify as a skilled nursing facility if it is used primarily for:

- ❑ Rest
- ❑ Mental health or substance use disorder treatment
- ❑ Custodial care or educational care

Spouse – The legal spouse of the covered employee or retiree.

Tiers (page 78) – Different levels that the Plan groups specialists and hospitals into, based upon an evaluation of certain quality and cost-efficiency measures.

8: Definitions

PART 2:
PRESCRIPTION DRUG PLAN

Description of Benefits

For questions about any of the information in Part 2 of this handbook, please contact CVS Caremark at 877-876-7214.

Administered by

CVS CAREMARK

Part 2: Prescription Drug Plan

CVS Caremark[1] is the pharmacy benefit manager for your prescription drug benefit plan. The CVS Caremark pharmacy network includes major chain pharmacies nationwide, many independent pharmacies, a mail service pharmacy and a specialty drug pharmacy.

If you have any questions about your prescription drug benefits, contact CVS Caremark Customer Care toll free at 877-876-7214, TDD: 800-238-0756.

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter versions of Preventive Drugs, medications are covered only if a prescription is required for their dispensing. Diabetes supplies and insulin are also covered by the plan.

The plan categorizes medications into seven major categories:

Generic Drugs

Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements help to assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug

A maintenance drug is a medication taken on a regular basis for chronic conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Brand-Name Drug

A non-preferred brand-name drug is a medication that usually has an alternative therapeutically equivalent drug available on the formulary.

Preferred Brand-Name Drug

A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost effectiveness.

Preventive Drugs

Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act. See preventive drugs on page 113 for more information.

1 CVS Caremark provides services through its operating company CaremarkPCS Health, L.L.C. and affiliates.

Specialty Drugs

Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- ❑ Potential for frequent dosing adjustments and intensive clinical monitoring
- ❑ Need for intensive patient training and compliance for effective treatment
- ❑ Limited or exclusive product distribution
- ❑ Specialized product handling and/or administration requirements

Over-the-Counter (OTC) Drugs

Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Preventive Drugs (all of which are covered only if dispensed with a written prescription).

Copayments

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit: Tier 1 (generic drugs), Tier 2 (preferred brand-name drugs), Tier 3 (non-preferred brand-name drugs), or drugs which require no copayments. The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

Table 7. Copayments for Prescription Drugs

Copayment for	Participating Retail Pharmacy up to 30-day supply	Mail Service or CVS Pharmacy up to 90-day supply
Tier 1 – Generic Drugs	$10	$25
Tier 2 – Preferred Brand-Name Drugs	$30	$75
Tier 3 – Non-Preferred Brand-Name Drugs	$65	$165
Other ▪ Orally-administered anti-cancer drugs ▪ Preventive Drugs: Refer to the "Preventive Drugs" section below for detailed information	$0	$0
Copayment for	**Specialty Drugs – One 30-day prescription allowed at any participating pharmacy; thereafter must be filled only through CVS Caremark Specialty Pharmacy**	
Specialty Drugs: Tier 1	$10 up to a 30-day supply	
Specialty Drugs: Tier 2	$30 up to a 30-day supply	
Specialty Drugs: Tier 3	$65 up to a 30-day supply	
Orally-administered anti-cancer specialty drugs	$0 up to a 30-day supply	

Out-of-Pocket Limit

This plan has an out-of-pocket limit that is separate from your medical and behavioral health out-of-pocket limit. Copayments you pay for prescription drugs during the year count toward this limit. Once you reach the limit, your prescription drugs are covered at 100%. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Table 8. Out-of-Pocket Limit

Individual	$1,500
Family	$3,000

How to Use the Plan

After you first enroll in the plan, CVS Caremark will send you a benefit booklet and CVS Caremark Prescription Card(s). Your prescription Card(s) will be mailed to you with ID cards for you and your dependents (if any) along with a booklet that includes a prescription drug benefit overview, drug list and a mail order claim form.

Show your new Prescription Card to your pharmacy so they can correctly process your prescription drug benefits.

Register on caremark.com. As a registered user, you can check drug costs, order mail service refills, and review your prescription drug history. You can access this site 24 hours a day.

Filling Your Prescriptions

You may fill your prescriptions for non-specialty drugs at any participating retail pharmacy, or through the CVS Caremark Mail Service Pharmacy. Prescriptions for specialty drugs must be filled as described in the “CVS Caremark Specialty Pharmacy” subsection.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your CVS Caremark Prescription Card, with the exception of the limited circumstances detailed in the “Claim Forms” subsection.

Short-Term Medications – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (example: antibiotics for strep throat or painkillers for an injury). Simply present your CVS Caremark Prescription Card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online after registering at caremark.com or by calling toll free at 877-876-7214.

If you do not have your Prescription Card, you can provide your pharmacist with the cardholder’s Social Security or GIC ID number, Bin number (004336), group code (RX7351) and the RxPCN code (ADV). The pharmacist can also verify eligibility by contacting the CVS Caremark Pharmacy Help Desk toll free at 800-421-2342, TDD: 800-238-0756.

Maintenance Medications – Up to 30 Days

After you fill two 30-day supplies of a maintenance medication at a retail pharmacy, you will receive a letter from CVS Caremark explaining how you may convert your prescription to a 90-day supply to be filled either through mail service or at a CVS Pharmacy. You will receive coverage for additional fills of that medication only if you convert your prescription to a 90-day supply to be filled either through mail service or at a CVS Pharmacy, or if you inform CVS Caremark that you instead prefer to continue to receive 30-day supplies at a participating retail pharmacy.

CVS Caremark will assist you in transitioning your maintenance prescription to either mail service or a CVS Pharmacy location.

Maintenance Medications – Up to 90 Days

Filling 90-day Prescriptions through CVS Caremark Mail Service Pharmacy or CVS Pharmacy

You have the choice and convenience of filling maintenance prescriptions for up to a 90-day supply at the mail service copayment, either through the CVS Caremark Mail Service Pharmacy or at a CVS Pharmacy.

Mail Service Pharmacy is a convenient option for prescription drugs that you take on a regular basis for conditions such as asthma, diabetes, high blood pressure and high cholesterol. Your prescriptions are filled and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection. They are delivered directly to your home or to another location that you prefer.

CVS Pharmacy is another option for getting your 90-day maintenance medications for the same copayment amount as mail service. Prescriptions can be filled at one of over 7,400 CVS Pharmacy locations across the country.

Convenient for You

You get up to a 90-day supply of your maintenance medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using mail service, or the option of your local CVS Pharmacy, you can order refills online or by phone.

Using Mail Service

To begin using mail service for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your maintenance medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a mail order form (contained in your Welcome Kit or found online after registering at caremark.com). Or call CVS Customer Care toll free at 877-876-7214 to request the form.
3. Put your prescription, payment and completed order form into the return envelope (provided with the order form) and mail it to CVS Caremark Mail Service Pharmacy.

Please allow 7-10 business days for delivery from the time your order is mailed. A pharmacist is available 24 hours a day to answer your questions about your medication.

If the CVS Caremark Mail Service Pharmacy is unable to fill a prescription because of a shortage of the medication, you will be notified of the delay in filling the prescription. You may then fill the prescription at a retail pharmacy, but the retail pharmacy copayment will apply.

CVS Caremark Specialty Pharmacy

CVS Caremark Specialty Pharmacy is a full-service specialty pharmacy that provides personalized care to each patient and serves a wide range of patient populations, including those with hemophilia, hepatitis, cancer, multiple sclerosis and rheumatoid arthritis.

You are allowed one fill of a specialty drug at any participating retail pharmacy. After the first fill, a specialty drug must be filled only at the CVS Caremark Specialty Pharmacy.

Specialty medications may be filled only at a maximum of a 30-day supply. They are subject to a clinical review by CVS Caremark's Specialty Guideline Management program to ensure the medications are being prescribed appropriately.

CVS Caremark Specialty Pharmacy offers a complete range of services and specialty drugs. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You have toll-free access to expert clinical staff who are available to answer all of your specialty drug questions. CVS Caremark Specialty Pharmacy will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CVS Caremark Specialty Pharmacy, call Specialty Customer Care toll free at 800-237-2767.

CVS Caremark Specialty Pharmacy Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office, a CVS Pharmacy or other approved location
- **Refill Reminders** – Ongoing refill reminders from CVS Caremark Specialty Pharmacy
- **Language Assistance** – Language interpreting services are provided for non-English speaking patients

Specialty Starter Fill Program

The Starter Fill program focuses on patients who are new to oral oncology therapies and may be more likely to stop treatment due to a high prevalence of side effects. This program restricts the dispensing of initial prescriptions (first fill) of select oral oncology medications to a limited supply (usually a 2-week supply). The partial fill allows time to ensure a new-to-therapy patient can tolerate the medication prior to filling a full 30-day supply. A pro-rated copay will apply.

Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your CVS Caremark Prescription Card, are covered as follows:

Table 9. Claims Reimbursement

Type of Claim	Reimbursement
Claims for prescriptions for plan members who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.[1]	Claims will be reimbursed at the full cost submitted, less the applicable copayment.
Claims for purchases at a participating (in-network) pharmacy without a CVS Caremark Prescription Card.	Claims incurred within 30 days of the member's eligibility effective date will be covered at full cost, less the applicable copayment. -or- Claims incurred more than 30 days after the member's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.
Claim forms are available to registered users on caremark.com or by calling 877-876-7214.	

Other Plan Provisions

Preventive Drugs

Coverage will be provided for the following drugs:[2]

Aspirin: Generic OTC versions when prescribed for adults age 45 or older for the prevention of heart attack or stroke. Generic OTC low-dose aspirin to help prevent illness and death from preeclampsia for females, after 12 weeks of pregnancy, who are at high risk for the condition.

Bowel preparation medications: Generic and brand prescription products for adults ages 50 to 75 years

Contraceptives: Generic and brand versions of contraceptive drugs and devices, and OTC contraceptive products, when prescribed for women

Folic acid supplements: Generic OTC versions when prescribed for women under the age of 56 planning or capable of pregnancy

Immunization vaccines: Generic or brand versions prescribed for children or adults. (Coverage for prescription drug vaccines only. No coverage of charges by pharmacies for the administration of vaccines.)

Oral fluoride supplements: Generic and brand supplements prescribed for children five years of age or under for the prevention of dental caries

1 Claims for medications filled outside the United States and Puerto Rico are covered only if the medications have U.S. equivalents.

2 This list is subject to change during the year. Call CVS Caremark toll free at 877-876-7214 to check if your drugs are included in the program.

Breast cancer:	Generic prescriptions for raloxifene or tamoxifen are covered for the primary prevention of breast cancer for females who are at increased risk, age 35 years and older
Tobacco cessation:	Generic, brand and OTC products prescribed for adults for the purpose of smoking cessation
Vitamin D supplements:	Single ingredient OTC products prescribed for adults age 65 years and older

Call CVS Caremark Customer Care at 877-876-7214 for additional coverage information on specific Preventive Drugs.

Brand-Name Drugs with Exact Generic Equivalents

The plan encourages the use of generic drugs. There are many brand-name drugs, such as Lipitor, Ambien and Fosamax, for which exact generic equivalents are available. If you fill a prescription for a brand-name medication for which there is an exact generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment. This amount does not count towards the out-of-pocket limit. Exceptions to this provision may apply to certain brand-name Preventive Drugs; contact CVS Caremark for additional information.

Prescription Drugs with Over-The-Counter (OTC) Equivalents or Alternatives

Some prescription drugs have OTC equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for prescription drugs with OTC equivalents. This provision is not applicable to Preventive Drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs. For example, OTC alternatives to Clarinex, a prescription drug, are the OTC products Allegra, Claritin and Zyrtec. Your plan does not provide benefits for prescription drugs when OTC alternatives are available. This provision is not applicable to Preventive Drugs.

Prior Authorization

Some drugs in your plan require prior authorization. Prior Authorization ensures that you are receiving the appropriate drug for the treatment of a specific condition, in quantities approved by the FDA. For select drugs, prior authorization also includes a medical necessity review that ensures the use of less expensive first-line formulary prescription drugs before the plan will pay for more expensive prescription drugs. First-line formulary prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases.

If a drug that you take requires prior authorization, your physician will need to contact CVS Caremark to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call CVS Caremark Prior Authorization at 800-294-5979.

Table 10. Current Examples of Drugs Requiring Prior Authorization for Specific Conditions[1]

Drug Class	Products Requiring Prior Authorization (PA)
Acne	Tazorac/Fabior
	Topical Retinoids (Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X, tretinoin, Veltin, Ziana) – *PA required only in adults age 36 and older*
Anabolic Steroids	Anadrol-50, Oxandrin
Antifungals, Topical	Ciclopirox Products, Lamisil, Itraconazole products
Compounded Medications*	Select medications * *A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available.*
Narcolepsy	Provigil, Nuvigil, Xyrem
Nutritional Supplements	Nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids
Opioid Dependency	Buprenorphine, Buprenorphine-nalaxone products (Bunavail, Suboxone, Zubsolv)
Pain	Oral-Intranasal Fentanyl (Abstral, Actiq, Fentora, Lazanda, Onsolis, Subsys)
	Butrans
Testosterone Products	Injectable, Oral, Topical/Buccal/Nasal products (AndroGel, Androderm, Axiron, Delatestryl, Depo-Testosterone, Fortesta, methyltestosterone, Natesto, Striant, Testim, Testosterone Cream, Testosterone Ointment, Testosterone Powder Vogelxo Topical Gel)
Weight Management	Adipex-P, Belviq, Benzphetamine, Bontril SR, Bontril PDM, Contrave, Didrex, Diethylpropion, Phendimetrazine/ER/SR, Phentermine, Qsymia, Regimex, Saxenda, Suprenza, Xenical
Miscellaneous	Regranex

Table 11. Current Examples of Top Drug Classes that May Require Prior Authorization for Medical Necessity[1]

Allergic Reaction (Anaphylaxis)	Glaucoma
Asthma	Insulin
Diabetic Supplies	Opioid Dependence Agents
Erectile Dysfunction	Pain/Inflammation- Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)

1 This list is not all inclusive and is subject to change during the year. Call CVS Caremark toll free at 877-876-7214 to check if your drugs are included in the program.

Select drugs within these classes require prior authorization for medical necessity to ensure formulary alternative(s) within the class have been tried. If you are a registered user on caremark.com, refer to the Advanced Formulary or call CVS Caremark toll-free for additional information.

Quantity Dispensing Limits

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- ❑ FDA-approved product labeling
- ❑ Common usage for episodic or intermittent treatment
- ❑ Nationally accepted clinical practice guidelines
- ❑ Peer-reviewed medical literature
- ❑ As otherwise determined by the plan

Examples of drugs with quantity limits currently include Cialis, Imitrex, and Oxycontin.[1]

Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- ❑ Adverse drug-to-drug interaction with another drug purchased through the plan;
- ❑ Duplicate prescriptions;
- ❑ Inappropriate dosage and quantity; or
- ❑ Too early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be filled.

1 This list is subject to change during the year. Call CVS Caremark toll free at 877-876-7214 to check if your drugs are included in the program.

Exclusions

Benefits exclude:[1]

- Nexium, Aciphex and esomeprazole
- Dental preparations (e.g. topical fluoride, Arestin), with the exception of oral fluoride
- Preventive Drugs for children six years of age or under
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and Preventive Drugs)
- Non-sedating antihistamines
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Allergens
- Hair growth agents
- Special medical formulas or food products, except as required by state law
- Bulk powders, bulk chemicals, and proprietary bases used in compounded medications

Definitions

Brand-Name Drug – The brand name is the trade name under which the product is advertised and sold, and during a period of patent protection it can only be produced by one manufacturer. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Compounded Medication – A compounded medication is one that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. At least one of the ingredients must be a medication that can only be dispensed with a written prescription.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Diabetes Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

FDA – The U.S. Food and Drug Administration.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The CVS Caremark formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary applies to medications that are dispensed in either the retail pharmacy or mail service settings. The formulary is developed and maintained by CVS Caremark. Formulary designations may change as new clinical information becomes available.

1 This list is subject to change during the year.

Generic Drugs – Generic versions of brand medications contain the same active ingredients as their brand counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand-name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

Maintenance Drug – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, diabetes, high blood pressure or high cholesterol.

Non-Preferred Brand-Name Drug – A non-preferred brand-name drug, is a medication that has been reviewed by CVS Caremark, which determined that an alternative drug that is clinically equivalent and more cost effective may be available.

Out-of-Pocket Limit – The out-of-pocket limit is the most you could pay in copayments during the year for prescription drugs that are covered by CVS Caremark. Once you reach this limit, you will have no more copayments for covered drugs. Payments for a brand drug when there is an exact generic equivalent and for drugs not covered by the plan do not count toward the out-of-pocket limit.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Preventive Drugs (all of which are covered only if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the CVS Caremark nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

Preferred Brand-Name Drug – A preferred brand-name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, and has been selected by CVS Caremark for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug means any and all drugs which, under federal law, are required, prior to being dispensed or delivered, to be labeled with the statement “Caution: Federal Law prohibits dispensing without prescription” or a drug which is required by any applicable federal or state law or regulation to be dispensed pursuant only to a prescription drug order.

Preventive Drugs – Preventive drugs consist primarily of drugs recommended for coverage by the U.S. Preventive Services Task Force, and as specified by the federal Patient Protection and Affordable Care Act.

Prior Authorization – Prior authorization means determination that a drug is appropriate for treatment of a specific condition. It may also mean determination of medical necessity, It is required before prescriptions for certain drugs will be paid for by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. These products require prior authorization to determine medical necessity.

To access the benefit for special medical formulas or food products, call the Group Insurance Commission at 617-727-2310, extension 1.

Specialty Drugs – Specialty drugs are usually injectable and non-injectable biotech or biological drugs with one or more of several key characteristics, including:

- ❑ Requirement for frequent dosing adjustments and intensive clinical monitoring
- ❑ Need for intensive patient training and compliance for effective treatment
- ❑ Limited or exclusive product distribution
- ❑ Specialized product handling and/or administration requirements

Member Appeals

CVS Caremark has processes to address:

- ❑ Inquiries concerning your drug coverage
- ❑ Appeals:
  - Internal Member Appeals
  - Expedited Appeals
  - External Review Appeals

All appeals should be sent to CVS Caremark at the following address:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 866-689-3092

All calls should be directed to Customer Care at 877-876-7214.

Internal Inquiry

Call Customer Care to discuss concerns you may have regarding your prescription drug coverage. Every effort will be made to resolve your concerns. If your concerns cannot be resolved or if you tell a Customer Care representative you are not satisfied with the response you have received, Customer Care will notify you of any options you may have, including the right to have your inquiry processed as an appeal. Customer Care will also provide you with the steps you and your doctor must follow to submit an appeal.

Internal Member Appeals

Requests for coverage that were denied as specifically excluded in this member handbook or for coverage that was denied based on medical necessity determinations are reviewed as appeals through CVS Caremark's Internal Appeals Process. You may file an appeal request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or prescription drug claim payment to file your appeal.

1. You must submit a written appeal to the address listed above. Your letter should include:
   - ❑ Your complete name and address;
   - ❑ Your CVS Caremark ID number;
   - ❑ Your Date of Birth;
   - ❑ A detailed description of your concern, including the drug name(s) being requested; and
   - ❑ Copies of any supporting documentation, records or other information relating to the request for appeal
2. The CVS Caremark Appeals Department will review appeals concerning specific prescription drug benefit provisions, plan rules, and exclusions and make determinations. If you are not satisfied with an Appeals Department denial related to a plan rule or exclusion (i.e., non-medical necessity appeal), you may have the right to request an independent External Review of the decision (refer to the "External Review Appeals" section for details on this process).

   For denials related to a medical necessity determination, you have the right to an additional review by CVS Caremark. CVS Caremark will request this review from an independent practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. If the second review is an adverse determination, you have the right to request an External Review of this decision (refer to the "External Review Appeals" section for details on this process).
3. For an appeal on a prescription drug that has not been dispensed, an Appeals Analyst will notify you in writing of the decision within no more than fifteen calendar days of the receipt of an appeal. For an appeal on a prescription drug already dispensed, an Appeals Analyst will notify you in writing of the decision within no more than thirty calendar days of the receipt of an appeal.

   A copy of the decision letter will be sent to you and your physician. A determination of denial will set forth:
   - ❑ CVS Caremark's understanding of the request;
   - ❑ The reason(s) for the denial;
   - ❑ Reference to the contract provisions on which the denial is based; and
   - ❑ A clinical rationale for the denial, if the appeal involves a medical necessity determination.

CVS Caremark maintains records of each inquiry made by a member or by that member's designated representative.

Expedited Appeals

CVS Caremark recognizes that there are circumstances that require a quicker turnaround than allotted for the standard Appeals Process. CVS Caremark will expedite an appeal when a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. If your request does not meet the guidelines for an expedited appeal, CVS Caremark will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a practitioner in the same or in a similar specialty that typically manages the medical condition for which the prescription drug has been prescribed. CVS Caremark will notify you of its decision by telephone no later than 72 hours after CVS Caremark's receipt of the request.

External Review Appeals

In most cases, if you do not agree with the Appeals decision, you or your authorized representative have the right to request an independent, external review of the decision. Should you choose to do so, send your request within four months of your receipt of the written notice of the denial of your appeal to:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 866-689-3092

In some cases, members may have the right to an expedited external review. An expedited external review may be appropriate in urgent situations. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

If you request an external review, an independent organization will review the decision and provide you with a written determination. If this organization decides to overturn the Appeals decision, the service or supply will be covered under the plan.

If you have questions or need help submitting an appeal, please call Customer Care for assistance at 877-876-7214.

Health and Prescription Information

Health and prescription information about members is used by CVS Caremark to administer benefits. As part of the administration, CVS Caremark may report health and prescription information to the administrator or sponsor of the benefit plan. CVS Caremark also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

PART 3:

BEHAVIORAL HEALTH PLAN

Description of Benefits for Mental Health, Substance Use Disorder and the Enrollee Assistance Program

For questions about any of the information in Part 3 of this handbook, please contact Beacon Health Options at 855-750-8980.

Administered by

Part I – How to Use this Plan

As a member of this plan, you are automatically enrolled in the mental health/substance use disorder benefits program and the Enrollee Assistance Program (EAP) administered by Beacon Health Options (Beacon). Beacon offers easy access to a wide variety of services, including assistance with day-to-day concerns and acute mental health and substance use disorder treatment. Beacon's comprehensive coverage ranges from traditional and intensive outpatient services to acute residential programs to acute inpatient care.

Beacon's member-driven and provider-centric approach seeks to improve your well-being and functioning as quickly as possible. Our primary goal is to offer you and your family "the right care, in the right setting, for the right amount of time" through our network of high quality, skilled providers.

How to Contact Beacon Health Options

Phone	**855-750-8980**	**TDD: 866-727-9441**
Website	**beaconhealthoptions.com/gic** (If prompted, type in plan/access code GIC)	The website offers wellness articles, a Beacon provider directory, benefits information, and other helpful tools.
Hours of Operations	**For specific benefits or claims questions:** Call a customer service representative Monday through Friday from 8 a.m. to 7 p.m., Eastern Time (ET). **For clinical support:** A qualified Beacon clinician will answer your call 24 hours a day, seven days a week, to verify your coverage and refer you to a specialized EAP resource or an in-network provider.	

How to Get Optimal Benefits

Taking two important steps will help you receive the highest level of benefits and lower your out-of-pocket expenses:

Step 1: **Use a provider or facility that is part of the Beacon Health Options network.**

Step 2: **Call Beacon Health Options to obtain a referral for EAP services, or to obtain prior authorization for non-routine outpatient and inpatient care.** For a list of non-routine services, see "Definitions of Beacon Health Options Behavioral Health Terms."

In-network providers – Beacon has a comprehensive network of experienced providers, all of whom have met our rigorous credentialing process. These in-network providers offer you the highest level of quality care for mental health, substance use disorder, and EAP services.

Out-of-network providers – Your benefits will be lower if you receive care from a provider or facility that is not part of Beacon's network. These reduced benefits are called out-of-network benefits.

Note: Benefits will be denied if your care is not considered a covered service.

We encourage you to call Beacon at 855-750-8980 (TDD: 866-727-9441) before you begin to use your mental health, substance use disorder, or EAP services. A qualified Beacon clinician will answer your call 24 hours a day, seven days a week, to assist you with both routine and urgent matters. Our clinicians can verify your coverage and refer you to an in-network provider who matches your specific request (e.g., provider location, gender, or fluency in a second language). Beacon clinicians can also provide you with a referral for brief counseling, or legal, financial, or dependent care assistance through your EAP.

Customer service representatives are also available from 8 a.m. to 7 p.m. ET to help you with specific benefits or claims questions.[1]

Referral/Prior Authorization for EAP and Non-Routine Services

You must obtain prior authorization for non-routine outpatient services and inpatient care requests. You must also obtain a referral from Beacon for EAP services. Beacon clinicians are available 24 hours a day, seven days a week at **855-750-8980** (**TDD: 866-727-9441**) to provide referrals and prior authorization.

After you obtain prior authorization, you can then call the provider of your choice directly to schedule an appointment. Beacon maintains an extensive database at **beaconhealthoptions.com/gic** where you can search for in-network providers.

If you (or your provider) do not call Beacon to obtain prior authorization or a referral, your benefits may be reduced or not paid at all.

Emergency Care

You should seek emergency care if you (or your covered dependents) need immediate clinical attention because you present a significant risk to yourself or others.

In a life-threatening emergency, you should seek care immediately at the closest emergency facility.

Beacon will not deny emergency care. However, ***you, a family member, or your provider must notify Beacon within 24 hours of an emergency admission.***

Although a representative may call on your behalf, it is always your responsibility to make certain that Beacon has been notified of an emergency admission. Your benefits may be reduced or denied if you do not notify Beacon.

> **Note:** If you call Beacon seeking non-life threatening emergency care, Beacon will connect you with appropriate services within six hours.

Urgent Care

You should seek urgent care if you have a condition that may become an emergency if it is not treated quickly. In such situations, our providers will have appointments to see you within 48 hours of your initial call to Beacon. Contact Beacon if you need assistance finding an in-network provider with urgent care appointment availability.

1 Supervisors monitor random calls to Beacon Health Options' customer services department as part of Beacon's quality control program.

Routine Care

Routine care is appropriate if you have a condition that presents no serious risk and is not likely to become an emergency. In-network providers will have appointments to see you within ten days of your initial call to Beacon for routine care. Contact Beacon if you need assistance finding an in-network provider with appointment availability.

Confidentiality

When you use your EAP, mental health, and substance use disorder benefits under this plan, you consent to release necessary clinical records to Beacon for case management and benefit administration. Information from your clinical records will be provided to Beacon only to the extent necessary to administer and manage the care provided when you use your benefits, and in accordance with state and federal laws. All of your records, correspondence, claims and conversations with Beacon staff are kept **completely confidential** in accordance with state and federal laws. No information may be released to your supervisor, employer or family without your written permission. No one will be notified when you use your EAP, mental health and substance use disorder benefits. However, if you inform Beacon that you are seriously considering harming yourself or others, Beacon is legally required to notify emergency services to ensure your safety, even without your permission.

Coordination of Benefits

You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use coordination of benefits (COB) to determine coverage for your mental health and substance use disorder benefits. All benefits under this plan are subject to COB. Beacon may request information from you about other health insurance coverage in order to process your claims.

Part II – Benefits

Benefits Explained

Your Member Costs

Deductible – A deductible is the amount you must pay each plan year before Beacon starts to pay for your out-of-network mental health and substance use disorder (behavioral health) services. You have a deductible of $300 for one person or $900 for the entire family for out-of-network behavioral health treatment. The most you'll owe for any one family member is $300, until the family as a whole reaches the $900 deductible limit. This deductible is shared between all covered medical and out-of-network behavioral health services.

Copayments (copays) – Copays are a set amount you pay when you get certain mental health or substance use disorder services. You have two different types of copays for behavioral health services under this plan:

- **Per-occurrence copays** – These are copays you pay every time you have a particular service. Outpatient visits all have per-occurrence copays.
- **Quarterly copays** – You pay quarterly copays only once per quarter, no matter how many times you get that service during the quarter. There are quarterly copays for inpatient and intermediate mental health and substance use disorder care. (The quarters are: July/August/September, October/November/December, January/February/March, and April/May/June.)

Out-of-Pocket Limit – The out-of-pocket limit is the maximum amount you will pay in deductibles and copays for your medical, mental health and substance use disorder care in one plan year. When you have met your out-of-pocket limit, all care will be covered at 100% of the allowed amount until the end of the year.

You have two separate out-of-pocket limits: an **out-of-pocket limit for in-network services, and an out-of-pocket limit for out-of-network services**. Neither limit includes the following:

- Charges for out-of-network care that exceeds the maximum number of days or visits
- Charges for care that is not a covered service
- Charges in excess of Beacon's allowed amounts

In-Network Benefits

Covered **in-network** services are paid at 100%, after copays (see copay schedule in Table 12, below). If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will only pay one copay. (The higher copay will apply).

In-network behavioral health services are not subject to the **deductible**.

The **out-of-pocket limit for in-network services** is $4,000 for one person or $8,000 for the entire family, shared with your in-network medical expenses. Only copays for covered in-network services apply to this limit. The cost of treatment that is subject to exclusions does not count toward the out-of-pocket limit. Once you reach your in-network out-of-pocket limit in a plan year, all covered in-network services you receive are covered at 100% until the end of that plan year.

Out-of-Network Benefits

Out-of-network benefits are paid at a lower level than in-network benefits and are subject to deductibles and copays. Out-of-network benefits are paid based on allowed amounts, which are Beacon's "reasonable and customary" fees, a percentage of Medicare, or negotiated fee maximums. Allowed amounts are subject to change at any time without notice. If your out-of-network provider or facility charges more than these allowed amounts, **you may be balance billed** (asked to pay for charges above the allowed amount). Beacon does not cover balance bills.

> Beacon's in-network providers must accept the Plan's allowed amounts, so you won't be balance billed as long as you use providers in the Beacon network. Call Beacon at 855-750-8980 (TDD: 866-727-9441) for help finding an in-network provider.

You have a **deductible** of $300 for one person or $900 for the entire family for out-of-network mental health and substance use disorder treatment.

The **out-of-pocket limit for out-of-network services** is $3,000 for one person. There is no family limit. Your out-of-network out-of-pocket limit applies only to your deductible and copays for out-of-network behavioral health services. Once each covered member reaches his or her out-of-network out-of-pocket limit in a plan year, all covered out-of-network services that person receives are covered at 100% of the allowed amount until the end of that plan year.

> **Important!** Once you have met your annual out-of-pocket limit, you continue to pay for any costs in excess of allowed amounts.

Table 12 outlines your costs for mental health, substance use disorder and EAP services.

Table 12. Mental Health, Substance Use Disorder, and EAP Benefits

Covered Services	In-Network Benefits	Out-of-Network Benefits
Deductible *Shared with applicable medical expenses*	None	$300 for one person, or $900 for the entire family
Out-of-Pocket Limit	$4,000 for one person, or $8,000 for the entire family *Shared with applicable medical expenses*	$3,000 for each person No family limit *Out-of-network behavioral health expenses only.*
Inpatient Care[1]		
Mental Health General hospital or psychiatric hospital	$150 inpatient care copay per quarter[2]	$200 inpatient care copay per quarter,[2] then 100% coverage of the allowed amount. Subject to deductible.
Substance Use Disorder General hospital or substance use disorder facility	$150 inpatient care copay per quarter[2]	$200 inpatient care copay per quarter,[2] then 100% coverage of the allowed amount. Subject to deductible.
Intermediate Care Including, but not limited to, 24-hour intermediate care facilities, e.g., crisis stabilization, day/partial hospitals, structured outpatient treatment programs	$150 inpatient care copay per quarter[2]	$200 inpatient care copay per quarter,[2] then 100% coverage of the allowed amount. Subject to deductible.
Outpatient Care – Mental Health, Substance Use Disorder and Enrollee Assistance Program		
Individual and Family Therapy[3]	$20 copay	$30 copay, then 100% coverage of the allowed amount. Subject to deductible.
Specialty Outpatient Services Autism Spectrum Disorder services, ECT, TMS, psychiatric VNA, neuropsychological / psychological testing, acupuncture detox, and DBT	$20 copay	$30 copay, then 100% coverage of the allowed amount. Subject to deductible.

1 You must obtain prior authorization for most inpatient, intermediate and hospital care. Please see Table 13, "Summary of Covered Services," or call Beacon at 855-750-8980 for details. You must notify Beacon within 24 hours of emergency admissions to receive maximum benefits.

2 Waived if readmitted within 30 days, with a maximum of one inpatient/intermediate care copay per quarter.

3 You receive up to 26 medically necessary individual/family therapy visits per member, per plan year without prior authorization. Prior authorization is required for individual/family visits (including therapy done in conjunction with medical management) beyond 26 per benefit year.

Table 12. Mental Health, Substance Use Disorder, and EAP Benefits *(continued)*

Covered Services	In-Network Benefits	Out-of-Network Benefits
Outpatient Care – Mental Health, Substance Use Disorder and Enrollee Assistance Program *(continued)*		
Group Therapy, all types Includes Autism Spectrum Disorder group therapy visits	$15 copay	$30 copay, then 100% coverage of the allowed amount. Subject to deductible.
Medication Management	$15 copay	$30 copay, then 100% coverage of the allowed amount. Subject to deductible.
Urine Drug Screening In conjunction with in-network substance use disorder treatment	No copay	No coverage
Provider Eligibility: Providers must be independently licensed in their specialty area or working under the supervision of an independently licensed clinician in a facility or licensed clinic. Examples include: MD psychiatrist, PhD, PsyD, EdD, LICSW, LMHC, LMFT, RNCS, BCBA.		
Enrollee Assistance Program (EAP) Including, but not limited to, depression, marital issues, family problems, alcohol and drug use, and grief. Also includes referral services – legal, financial, child and elder care **Note:** All EAP services require you to obtain a referral from Beacon. Failure to do so results in loss of coverage.	**Counseling:** Up to 3 visits per member per year, with no copay **Legal:** 30-minute consultation with a local independent attorney and 25% off the hourly rate for services beyond the initial consultation **Financial:** ▪ 30-minute phone consultation with a financial counselor for assistance with issues such as credit repair, debt management, and budgeting ▪ 30-minute phone consultation with a local, independent financial planner, and 15% off his/her standard rate for preparing a financial plan **Child and elder care:** access to referrals in your area **Domestic violence resources:** access to a confidential hotline and supportive services	No coverage

What This Plan Pays: Summary of Covered Services

The Plan pays for the services listed in Table 13. All services must meet medical necessity criteria to be covered.

Table 13. Summary of Covered Services[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Acupuncture Detoxification	Individual/Family Therapy	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** No **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Acute Inpatient Psychiatric Services	Inpatient Care	Yes
Acute Residential Treatment	Intermediate Care	Yes
Adolescent Acute Inpatient Detoxification and Rehabilitation for Substance Use Disorder	Inpatient Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.
Adult Crisis Stabilization Unit (CSU)	Intermediate Care	Yes
Ambulatory Detoxification	Medication Management	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** No **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required
Applied Behavior Analysis (ABA)	Individual/Family Therapy	Yes
Clinical Stabilization Services (CSS) for Substance Use Disorder (Level 3.5)	Intermediate Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.
Community Based Acute Treatment (CBAT)	Intermediate Care	Yes

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 139). Failure to obtain prior authorization, when required, may result in no coverage.

Table 13. Summary of Covered Services *(continued)*[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Community Support Programs (CSP)	Intermediate Care	Yes
Day Treatment	Intermediate Care	Yes
Dialectical Behavioral Therapy (DBT)	Individual/Family Therapy	Yes
Drug Screening (urine) *In conjunction with substance use disorder treatment*	No copay (covered in-network only)	No
Dual Diagnosis Acute Treatment (DDAT)	Intermediate Care	**In-Network:** No prior authorization required for 1st three days of treatment. Subsequent days require authorization. **Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.
Electroconvulsive Therapy (ECT)	Individual/Family Therapy	Yes
Emergency Service Programs (ESP)	No copay	No
Enrollee Assistance Program (EAP)	No copay	Yes (referral)
Family Stabilization Team (FST)	Intermediate Care	Yes
Group Therapy	Group Therapy	No
Individual/Family Therapy (conducted in the provider's office/facility, or, if appropriate, in a member's home)	Individual/Family Therapy	Prior authorization is required for more than 26 visits per plan year.
Inpatient Substance Use Disorder Services – Medically Managed (Level 4 detox)	Inpatient Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 139). Failure to obtain prior authorization, when required, may result in no coverage.

Table 13. Summary of Covered Services *(continued)*[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Intensive Outpatient Programs (IOP) for Mental Health	Intermediate Care	**In-Network:** No, for first 6 units within 14 days. Authorization required for subsequent units. **Out-of-Network:** Prior authorization required.
Intensive Outpatient Programs (IOP) for Substance Use Disorder	Intermediate Care	**In-Network:** No, for first 6 units within 14 days. Authorization required for subsequent units. **Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.
Medication Management	Medication Management	No
Methadone Maintenance	No copay	No
Observation	Inpatient Care	Yes
Partial Hospitalization Programs (PHP) for Mental Health	Intermediate Care	Yes
Partial Hospitalization Programs (PHP) for Substance Use Disorder	Intermediate Care	**MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.
Psychiatric Visiting Nurse services	Individual/Family Therapy	Yes
Psychological and Neuropsychological Testing	Individual/Family Therapy	Yes
Residential Detoxification-Medically Monitored/Acute Treatment Services (Level 3.7 Detox)	Intermediate Care	**In-Network, or Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 139). Failure to obtain prior authorization, when required, may result in no coverage.

Table 13. Summary of Covered Services *(continued)*[1]

Service	Applicable Copay type (see grid above for copay amounts)	Prior Authorization Required?
Structured Outpatient Addictions Programs (SOAP)	Intermediate Care	**In-Network:** No authorization required for initial 20 units in 45 days per member. Authorization required for subsequent units. **Out-of-Network, MA DPH Licensed Provider:** Notification of admission required within 48 hours. **Out-of-Network, Non-MA DPH Licensed Provider:** Prior authorization required.
Substance Use Disorder Assessment and Referral	No copay	No
Transcranial Magnetic Stimulation (TMS)	Individual/Family Therapy	Yes
Transitional Care Unit (TCU)	Intermediate Care	Yes

All services must be deemed covered services and all charges are subject to the Plan's allowed amount for that service.

Covered Services

Routine Outpatient Services

Routine Services – Routine outpatient services (listed below) do not require prior authorization.

- ❑ Outpatient therapy (individual/family therapy, including therapy done in conjunction with medication management), up to 26 visits per member, per year
- ❑ Group therapy that is 45 to 50 minutes in duration
- ❑ Medication management
- ❑ Methadone maintenance
- ❑ In-network urine drug screening as a medically necessary part of substance use disorder treatment
- ❑ Emergency service programs (ESP)

Outpatient therapy visits beyond 26 per plan year are defined as non-routine and require prior authorization.

Routine out-of-network outpatient care is paid at 100% of the allowed amount, after a $30 copay per visit. Out-of-network outpatient care is subject to the deductible.

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one copay. (The higher copay will apply.)

1 These services are subject to certain exclusions, which can be found in "What's Not Covered – Exclusions" (page 139). Failure to obtain prior authorization, when required, may result in no coverage.

Non-Routine (Specialty) Outpatient Services

Non-Routine (Specialty) Outpatient Services – ***You must obtain prior authorization for most non-routine outpatient care.*** Please see Table 13, "Summary of Covered Services," for details on authorization requirements. Failure to obtain prior authorization for non-routine outpatient care may result in no coverage.

Please see "Definitions of Beacon Health Options Behavioral Health Terms" (page 142) for a full listing of non-routine services.

If you receive multiple outpatient behavioral health services on the same day, from the same provider, you will be charged one copay. (The higher copay will apply.)

Autism Spectrum Disorders – The plan will cover medically necessary services provided for the diagnosis and treatment of autism spectrum disorders. Coverage is pursuant to the requirements of the plan and to Massachusetts law, including, without limitation:

- ❑ Professional services, including care by appropriately credentialed, licensed or certified psychiatrists, psychologists, social workers, and board-certified behavior analysts.
- ❑ Habilitative / rehabilitative care, including, but not limited to, Applied Behavior Analysis (ABA) by a board-certified behavior analyst as defined by law.

Beacon's specialized autism case managers can provide any necessary prior authorization and help you locate an in-network provider. Please call Beacon at 855-750-8980 to speak to an **autism case manager**.

- ❑ **Applied Behavior Analysis Services (ABA)** – Coverage for ABA-related services is based on medical necessity criteria. ***You must obtain prior authorization for all ABA services.*** Failure to obtain prior authorization may result in no coverage. Covered services include:
  - Skills assessment by a Board Certified Behavioral Analyst (BCBA) or qualified licensed clinician
  - Conjoint supervision of paraprofessionals by a BCBA or qualified licensed clinician, with clients present
  - Treatment planning conducted by a BCBA or qualified licensed clinician
  - Direct ABA services by a BCBA, licensed clinician, or paraprofessional (if appropriately supervised)
- ❑ **Psychiatric Services** – Psychiatric services for autism spectrum disorders are focused on treating maladaptive/stereotypic behaviors that pose a danger to self, others and/or property, and impair daily functioning. Covered services include:
  - Diagnostic evaluations and assessment
  - Treatment planning
  - Referral services
  - Medication management
  - Inpatient/24-hour supervisory care ***(prior authorization required)***
  - Partial Hospitalization/Day Treatment ***(prior authorization required)***
  - Intensive Outpatient Treatment ***(prior authorization required)***
  - Services at an Acute Residential Treatment Facility ***(prior authorization required)***
  - Individual, family, therapeutic group, and provider-based case management services

- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family
- Crisis Intervention
- Transitional Care ***(prior authorization required)***

Psychological/Neuropsychological Testing

You must obtain prior authorization for psychological testing. Failure to obtain prior authorization for psychological testing may result in no coverage.

You must obtain prior authorization for neuropsychological testing for mental health conditions. Failure to obtain prior authorization for neuropsychological testing may result in no coverage.

> **Note:** Neuropsychological testing for medical conditions is covered under the medical component of your plan.

Urine Drug Screening

In-network urine drug screening is covered when it is a medically necessary part of substance use disorder treatment. (Screening that is conducted as part of methadone treatment is billed as part of the methadone services.)

Urine drug screening must be done by certified in-network providers. Beacon does not provide coverage for out-of-network providers or laboratories, or for uncertified in-network providers.

> **Note:** Urine drug screens completed by laboratories or out-of-network providers *may* be covered by the medical component of your plan. Contact UniCare at 800-442-9300 for information about coverage under the medical component of your plan.

Intermediate Care

In-network intermediate care in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $150 copay per quarter. The copay is waived if you are readmitted within 30 days of discharge.

Out-of-network intermediate care is paid at 100% of the allowed amount, after a $200 copay per quarter. Out-of-network intermediate care is subject to the deductible.

You or your provider must obtain prior authorization for intermediate care. Failure to obtain prior authorization may result in no coverage.

Inpatient Care

In-network inpatient care in a general or psychiatric hospital or a substance use disorder facility is covered at 100%, after a $150 copay per quarter. The copay is waived if you are readmitted within 30 days of discharge.

Out-of-network inpatient care in a general or psychiatric hospital or a substance use disorder facility is paid at 100% of the allowed amount, after a $200 copay per quarter. Out-of-network inpatient care is subject to the deductible. If you are admitted to an out-of-network inpatient facility through an emergency room, and there are no in-network providers available, the inpatient admission will be covered at the in-network benefit level.

If you require psychiatry visits/consultations while receiving inpatient care, these visits will be covered at 100%.

You or your provider must obtain prior authorization for inpatient care. Failure to obtain prior authorization may result in no coverage.

Enrollee Assistance Program (EAP)

The Enrollee Assistance Program (EAP) is an in-network only benefit.

Beacon's EAP can help with the following types of problems:

1. Breakup of a relationship
2. Divorce or separation
3. Becoming a stepparent
4. Helping children adjust to new family members
5. Death of a friend or family member
6. Communication problems
7. Conflicts in relationships at work
8. Legal difficulties
9. Financial difficulties
10. Child care or elder care needs
11. Aging
12. Traumatic events

Call 855-750-8980 (TDD: 866-727-9441) to use your EAP benefit. A Beacon clinician will refer you to a trained EAP provider and/or other specialized resource (e.g., attorney or dependent care service) in your community. The Beacon clinician may recommend mental health and substance use disorder services if the problem seems to require help that is more extensive than EAP services can provide.

You must call to receive a referral from Beacon for all EAP services. Failure to obtain a referral may result in no coverage.

Covered services include:

- ❑ **EAP Counseling Visits** – You have access to up to three EAP counseling visits per member, per year, with an in-network licensed provider. EAP counseling visits can help with problems affecting work/life balance or daily living, such as marital problems, stress at work, or difficulties adjusting to life changes. These visits are covered at 100%.
- ❑ **Legal Services** – Legal assistance services include confidential access to a local attorney to help you answer legal questions, prepare legal documents and help solve legal issues. The following free or discounted services are provided through though your legal benefit:
  - Free referral to a local attorney
  - Free 30-minute consultation (phone or in-person) per legal matter
  - 25% off the attorney's hourly rate (if the attorney charges by the hour) for services beyond the initial consultation
  - Free online legal information, including common forms and will kits
- ❑ **Financial Counseling and Planning** – Your financial counseling and planning benefit includes:
  - A 30-minute initial phone consultation with a financial counselor for assistance with issues such as credit repair, debt management, and budgeting
  - A 30-minute initial phone consultation with a local, independent financial planner, and 15% off his or her standard rate for preparing a financial plan

- ❑ **Child/Elder Care Referral Service** – Beacon's EAP can help you locate a child or elder care provider. You will receive a packet that contains informational literature, links to federal and private agencies, and a list of independent referrals in your area. There is no cost for this referral service.
- ❑ **Domestic Violence Resources and Assistance** – You have 24/7 access to a confidential, toll-free hotline that provides crisis intervention, safety planning, supportive listening, and help connecting to appropriate resources. Beacon's EAP can also provide referrals to a wide range of supportive services, including specialized counseling, temporary emergency housing, and legal assistance.
- ❑ **Employee Assistance Program for Agency Managers and Supervisors** – The Group Insurance Commission offers an Employee Assistance Program for managers and supervisors of agencies and municipalities, which offers:
  - Critical incident response services (also available to non-managers and supervisors)
  - Confidential consultations
  - Resources for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness and substance use disorder
  - Team trainings on topics such as stress management and coping with challenging workplace behaviors

Case Management

Beacon's clinical case managers are available to support you and your family. Case managers will:

- ❑ Help determine the appropriate treatment for you
- ❑ Review your case using objective and evidence-based clinical criteria
- ❑ Help coordinate services among multiple providers
- ❑ Work with your providers to support your needs
- ❑ Provide available resources
- ❑ Work with your medical plan to help coordinate benefits and services
- ❑ Provide psychoeducation
- ❑ Encourage the development of a care plan to help with transitions in care

If you would like help dealing with your behavioral health situation, call Beacon at 855-750-8980 (TDD: 866-727-9441) and ask to speak with a case manager.

What's Not Covered – Exclusions

This plan does not cover services, supplies or treatment relating to the below exclusions. The exclusions apply even if the services, supplies or treatment are recommended or prescribed by your provider, or if they are the only available options for your condition.

Excluded services include:

- Services performed in connection with conditions not classified in the most current edition of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM)
- Prescription drugs or over-the-counter drugs and treatments.

  Note: These supplies may be covered under the prescription drug component of your plan.

- Services or supplies for mental health/substance use disorder treatment that, in Beacon's reasonable judgment, fits any of the following descriptions:
  - Is not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance use disorder
  - Is not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
  - Is not consistent with prevailing professional research which would demonstrate that the service or supplies will have a measurable and beneficial health outcome
  - Typically does not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; or that are consistent with Beacon's level-of-care clinical criteria, clinical practice guidelines or best practices as modified from time to time.

  Beacon may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Services, supplies or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment or device is the only available treatment for a particular condition will not result in it being a covered service if it is considered unproven, investigational or experimental.
- Custodial care, unless necessary for acute stabilization or to return you to your baseline level of individual functioning. Care is considered custodial when it:
  - Is primarily intended for detention in a protected, controlled environment
  - Is chiefly designed to assist in the activities of daily living, or
  - Cannot reasonably be expected to restore you to a level of functioning that would enable you to function outside a structured environment. (This applies to members for whom there is little expectation of improvement, despite any and all treatment attempts.)
- Neuropsychological testing solely to determine a diagnosis of attention-deficit hyperactivity disorder.

  Note: Neuropsychological testing for medical conditions is covered under the medical component of your plan.

- Urine drug screening is excluded when:
  - Conducted as part of your participation in methadone treatment, which is billed as part of the methadone services
  - Completed by out-of-network providers, laboratories, or in-network providers who are not certified
- Examinations or treatment, when:
  - Required solely for purposes of career, education, housing, sports or camp, travel, employment, insurance, marriage, or adoption; or
  - Ordered by a court except as required by law; or
  - Conducted for purposes of medical research; or
  - Required to obtain or maintain a license of any type

  The above examinations or treatment may be covered if they are: (1) otherwise considered covered behavioral health services, and (2) determined by Beacon to be medically necessary.
- Herbal medicine, or holistic or homeopathic care, including herbal drugs or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Biofeedback
- Equestrian or pet therapy
- Any service, program, supply, or procedure performed in a non-conventional setting (including, but not limited to, spas/resorts, therapeutic/residential schools, educational, vocational, or recreational settings; daycare or preschool settings; Outward Bound; or wilderness, camp or ranch programs), even if performed or provided by licensed providers (including, but not limited to, nutritionists, nurses or physicians).
- Multiple charges for the same service or procedure, on the same date.
- Facility charges for covered outpatient services.
- Nutritional counseling

  Note: These services are covered under the medical component of your plan.
- Professional anesthesia services related to electroconvulsive treatment (ECT)

  Note: These services are covered under the medical component of your plan.
- Weight reduction or control programs, special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment from unlicensed providers, including pastoral counselors (except as required by law), or services or treatment outside the scope of a provider's licensure.
- Personal convenience or comfort items, including but not limited to TVs, telephones, computers, beauty or barber services, exercise equipment, air purifiers, or air conditioners.
- Light boxes and other equipment, including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while you are confined in a facility.

- Surgical procedures including but not limited to gender reassignment surgery.

  Note: The medical component of your plan provides coverage for many surgical procedures, including gender reassignment surgery.

- Smoking cessation related services and supplies.

  Note: These services and supplies are covered under the medical and prescription drug components of your plan.

- Travel or transportation expenses, unless Beacon has requested and arranged for you to be transferred by ambulance from one facility to another.
- Services performed by a provider who is your family member by birth or marriage, including a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as you.
- Mental health and substance use disorder services that you have no legal responsibility to pay, or that would not ordinarily be charged in the absence of coverage under the plan.
- Charges in excess of any specified plan limitations.
- Charges for missed appointments.
- Charges for record processing, except as required by law.
- Services provided under another plan, or services or treatment that must be purchased or provided through other arrangements under federal, state or local law. This includes but is not limited to coverage required by workers' compensation, no-fault auto insurance, or similar legislation. Benefits will not be paid if you could have elected workers' compensation or coverage under a similar law (or could have it elected for you).
- Behavioral health services received as a result of war or any act of war (declared or undeclared) or caused during service in the armed forces of any country when you are legally entitled to other coverage.
- Treatment or services received prior to your eligibility for coverage under the plan or after your coverage under the plan ends.

Part III – Definitions, Appeals, Complaints and Grievances

Definitions of Beacon Health Options Behavioral Health Terms

Allowed amounts – The maximum amount Beacon will reimburse for services or treatment. Beacon's allowed amounts can be based on "reasonable and customary fees," a percentage of Medicare, or negotiated fee maximums. If your out-of-network provider or facility charges more than these allowed amounts, you may be responsible for the difference, in addition to any amount not covered by the benefit. Out-of-network rates or allowed amounts are not contracted rates and are subject to change at any time without notification.

Appeal – A formal request for Beacon to reconsider any adverse determination or denial of coverage for admissions, continued stays, levels of care, procedures or services. Appeals can occur either concurrently or retrospectively.

Beacon Health Options (Beacon) clinician – A licensed master's level or registered nurse behavioral health clinician who provides prior authorization for EAP, mental health and substance use disorder services. Beacon clinicians have three or more years of clinical experience, Certified Employee Assistance Professionals (CEAP) certification or eligibility, and a comprehensive understanding of the full range of EAP services.

Case management – Beacon's clinical case managers can help support you and your family by helping to determine the appropriate treatment; reviewing your case; coordinating benefits and services; providing available resources; working with your providers; encouraging development of a care plan; and/or providing psychoeducation.

Complaint – A verbal or written statement of dissatisfaction to Beacon concerning a perceived adverse administrative action, decision or policy.

Continuing review or concurrent review – A clinical case manager works closely with the provider to determine the appropriateness of continued care, review the current treatment plan and progress, and discuss your future care needs.

Coordination of Benefits (COB) – You and your dependents may be entitled to receive benefits from more than one plan. When this occurs, your plans use coordination of benefits (COB) to determine the order and proportion of coverage for your mental health and substance use disorder benefits. COB regulations determine which insurer has primary responsibility for payment and pays first, and which insurer has secondary responsibility for any charges not covered by the primary plan.

Copayment (copay) – A set amount you pay when you get certain mental health or substance use disorder services.

Cost sharing – The amount that you pay for the cost of services. This includes any applicable copays and deductibles.

Covered services – Services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance use disorder. Covered services are described in "What This Plan Pays: Summary of Covered Services." The items under "What's Not Covered – Exclusions" are **not** covered services.

Deductible – A set amount you pay for certain mental health and substance use disorder services each plan year before Beacon starts paying for those services. Your deductible starts on July 1 each year.

Intermediate care – Care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. This includes, but is not limited to, partial hospitalization programs and residential detoxification.

In-network provider – A provider that participates in the Beacon network.

Member – A person who is enrolled in this plan through the Group Insurance Commission.

Non-routine services – Specialty services that require prior authorization. Non-routine services include:

- ❑ Individual/family outpatient therapy visits (including therapy conducted in conjunction with medication visits) beyond 26 visits per member in a year.
- ❑ Intensive outpatient treatment programs provided by a non-Massachusetts DPH-licensed provider
- ❑ Electroconvulsive treatment (ECT)

  Note: Professional anesthesia services are covered under the medical component of your plan.

- ❑ Psychological testing
- ❑ Neuropsychological testing for a mental health condition
- ❑ Applied Behavior Analysis (ABA)
- ❑ Transcranial Magnetic Stimulation (TMS)
- ❑ Acupuncture detoxification provided by a non-Massachusetts DPH-licensed provider
- ❑ Ambulatory detoxification provided by a non-Massachusetts DPH-licensed provider
- ❑ Community support programs
- ❑ Day treatment
- ❑ Dialectical Behavioral Therapy (DBT)
- ❑ Enrollee Assistance Program (EAP)
- ❑ Family stabilization team (FST)
- ❑ Psychiatric visiting nurse services

Out-of-network provider – A provider that does not participate in the Beacon network.

Out-of-pocket limit – The maximum amount you will pay in deductibles and copays for your medical, mental health and substance use disorder care in one plan year. When you have met your out-of-pocket limit, all care will be covered at 100% of the allowed amount until the end of the year. This limit does not include charges for out-of-network care that exceed the maximum number of covered days or visits, charges for care that is not a covered service, or charges in excess of Beacon's allowed amounts.

Prior authorization – The process of contacting Beacon prior to seeking non-routine mental health or substance use disorder care, or for a referral to Enrollee Assistance Program (EAP) services. All prior authorization is performed by Beacon clinicians.

Routine services – A customary service that does not require prior authorization. Routine services include outpatient therapy (individual/family), up to 26 visits per member in a year, including therapy done in conjunction with medication management visits; group therapy of 45 to 50 minutes in duration; medication management; methadone maintenance; in-network urine drug screening as a medically necessary part of substance use disorder treatment; and emergency service programs (ESP). Outpatient therapy visits over 26 per year are considered non-routine and require prior authorization.

Filing Claims

In-network providers and facilities will file your claim for you. You are financially responsible for in-network copays.

Out-of-network providers are not required to process claims on your behalf; you may have to submit the claims yourself. You are responsible for your out-of-network deductible and copays. **If you are required to submit the claim yourself**, you can send a completed CMS 1500 claim form, along with the out of network provider's itemized bill, with your name, address and GIC ID number, to the following address:

Beacon Health Options
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801

You may also submit a claim for reimbursement through our online portal: mybeacon.beaconhs.com or on a completed Member Reimbursement claim form, along with proof of payment, to the following address:

Beacon Health Options
GIC Member Reimbursements
PO Box 527
Woburn, MA 01801

The CMS 1500 form is available from your provider or at beaconhealthoptions.com/gic. The Member Reimbursement claim form can be found at beaconhealthoptions.com/gic. (If prompted, type in access code GIC.) Beacon must receive all claims within 24 months of the date of service for you or your dependents. You must have been eligible for coverage on the date you received care, and treatment must be medically necessary. All claims are confidential.

Complaints

We encourage you to speak with a Beacon customer service representative if you are not satisfied with any aspect of our program. You can reach Beacon at 855-750-8980 (TDD: 866-727-9441) Monday through Friday from 8 a.m. to 7 p.m. ET. Beacon's member services representatives can resolve most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at Beacon, including clinicians, claims representatives, administrators and other managers who report directly to senior corporate officers. We will respond to all inquiries within three business days.

We want to hear from you. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal written complaint within 60 days of the date of our telephone call or letter of response. Beacon will respond to all formal complaints in writing within 30 days.

To submit a formal written complaint regarding a mental health or substance use disorder concern, please contact:

Ombudsperson
Beacon Health Options
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801

Formal written complaints should include any information you feel is relevant. Please specify the dates of service and any additional contact you have had with Beacon.

Appeals

Your Right to an Internal Appeal

You, your treating provider, or someone acting on your behalf has the right to request an appeal of Beacon's benefit decisions. You may request an appeal by following the steps below.

> **Note:** If your care needs are urgent (meaning that a delay in making a treatment decision could significantly increase your health risks or affect your ability to regain maximum functioning), please see the section below titled "How to Initiate an Urgently Needed Determination (Urgent Appeal)."

How to Initiate a First Level Internal Appeal (Non-Urgent Appeal)

Your appeal request must be submitted to Beacon within 180 calendar days of your receipt of the notice of the coverage denial.

Written requests should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801
855-750-8980 (TDD: 866-727-9441)
Fax: 781-994-7636

Appeal requests must include:

- ❑ The member's name and identification number
- ❑ The date(s) of service(s)
- ❑ The provider's name
- ❑ The reason you believe the claim should be paid
- ❑ Any documentation or other written information to support your request for claim payment

The Appeal Review Process (Non-Urgent Appeal)

If you request an appeal review of a denial of coverage, the review will be conducted by someone who was not involved in the initial coverage denial, and who is not a subordinate to the person who issued the initial coverage denial.

For a non-urgent appeal review, a Beacon clinician will review the denial and notify you of the decision, in writing, within 15 calendar days of your request.

For an appeal review of a denial of coverage that has already been provided to you, Beacon will review the denial and will notify you in writing of Beacon's decision within 30 calendar days of your request.

You may bypass Beacon's internal review process and request an external review by an independent review organization, which will review your case and make a final decision, if Beacon exceeds the time requirements for making a determination and providing notice of the decision.

If Beacon continues to deny the payment, coverage or service requested, you may request an external review by an independent review organization, that will review your case and make a final decision. This process is described in the "Independent External Review Process (Non-Urgent Appeal)" section below.

Independent External Review Process (Non-Urgent Appeal)

You have the right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is required by law to accept the determination of the IRO in this external review process.

You, your provider, or someone you consent to act for you (your authorized representative) can make this request. Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801
855-750-8980 (TDD: 866-727-9441)
Fax: 781-994-7636

Independent External Review requests must include:

- ❑ Your name and identification number
- ❑ The dates of service that were denied
- ❑ Your provider's name
- ❑ Any information you would like to be considered, such as records related to your current symptoms and treatment, co-existing conditions, or any other relevant information you believe supports your appeal

If you request an independent external review, Beacon will complete a preliminary review within five business days to determine whether your request is complete and eligible for an independent external review.

Additional information about this process, and your member rights and appeal information, is available at beaconhealthoptions.com/gic (if prompted, type in plan/access code GIC), or by speaking with a Beacon representative.

How to Initiate an Urgently Needed Determination (Urgent Appeal)

In general, an urgent situation is one in which your health may be in serious jeopardy, or in which your provider believes that delaying a treatment decision may significantly increase your health risks or affect your ability to regain maximum function. If you believe that your situation is urgent, contact Beacon immediately to request an urgent review. If your situation meets the definition of urgent, Beacon will conduct the review on an expedited basis.

You may also request that an independent third party conduct a separate urgent review (see below) at the same time. You, your provider, or your authorized representative may request a review. Contact Beacon if you wish to name an authorized representative to request a review on your behalf.

Beacon will make a determination and notify you verbally and in writing within 72 hours of your request for an urgent review. If Beacon continues to deny the payment, coverage or service requested, you may request an external review by an independent review organization that will review your case and make a final decision. This process is described in the "Independent External Review Process (Urgent Appeal)" section below.

Independent External Review Process (Urgent Appeal)

You have a right to request an external review by an Independent Review Organization (IRO) of a decision made to not provide you a benefit or pay for an item or service (in whole or in part). Beacon is legally required to accept the determination of the IRO in this external review process.

You, your provider or your authorized representative may make a request. Requests must be made in writing within 180 calendar days of receipt of your non-coverage determination notice.

Written requests for independent external review should be submitted to the following address:

Beacon Health Options
Appeals Department
500 Unicorn Park Drive
Suite 103
Woburn, MA 01801
855-750-8980 (TDD: 866-727-9441)
Fax: 781-994-7636

Independent External Review requests must include:

- ❑ Your name and identification number
- ❑ The dates of service that were denied
- ❑ Your provider's name
- ❑ Any information you would like to have considered, such as records related to the current conditions of treatment, co-existent conditions or other relevant information

If you request an independent external review for an urgent request, Beacon will complete an immediate preliminary review to determine whether your request is complete and eligible for an independent external review.

You can find additional information about this process and your member rights and appeal information at beaconhealthoptions.com/gic. (If prompted, type in access code GIC.) You can also call 855-750-8980 (TDD: 866-727-9441) to speak with a Beacon representative.

APPENDICES

Appendix A: GIC Notices

Appendix B: Forms

Appendix C: Federal and State Mandates

Appendix D: Your Right to Appeal

Appendix A: GIC Notices

- ❑ Notice of Group Insurance Commission (GIC) Privacy Practices
- ❑ Important Notice from the GIC about Your Prescription Drug Coverage and Medicare
- ❑ The Uniformed Services Employment and Reemployment Rights Act (USERRA)
- ❑ Overview of Health Insurance Marketplaces

Notice of Group Insurance Commission (GIC) Privacy Practices

Effective September 3, 2013

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.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at mass.gov/gic.

Required and permitted uses and disclosures

We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make *without* your authorization:

Payment activities

The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health care operations

The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

To provide you information on health-related programs or products

Such information may include alternative medical treatments or programs or about health-related products and services, subject to limits imposed by law as of September 23, 2013.

Other permitted uses and disclosures

The GIC may use and share PHI as follows:

- To resolve complaints or inquiries made by you or on your behalf (such as appeals);
- To enable business associates that perform functions on our behalf or provide services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Our business associates are also directly subject to federal privacy laws;
- For data breach notification purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access or disclosure of your health information;
- To verify agency and plan performance (such as audits);
- To communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- For judicial and administrative proceedings (such as in response to a court order);
- For research studies that meet all privacy requirements; and
- To tell you about new or changed benefits and services or health care choices.

Required disclosures

The GIC **must** use and share your PHI when requested by you or someone who has the legal right to make such a request on your behalf (your Personal representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that assist us

In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI and also have direct responsibility to protect your PHI imposed by federal law.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this by in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.

- ❑ Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- ❑ Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- ❑ Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- ❑ Receive notification of any breach of your unsecured PHI.
- ❑ Receive a separate paper copy of this notice upon request. (An electronic version of this notice is on our website at **mass.gov/gic**.)

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call 617-727-2310, extension 1 or TTY for the deaf and hard of hearing at 617-227-8583.

Important Notice from the GIC about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UniCare State Indemnity Plan/Basic and your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a non-GIC Medicare drug plan. If you are considering joining a non-GIC plan, you should compare your current coverage – particularly which drugs are covered, and at what cost – with that of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage can be found at the end of this notice.

For most people, the drug coverage that you currently have through your GIC health plan is a better value than the Medicare drug plans.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available to everyone with Medicare in 2006. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The GIC has determined that the prescription drug coverage offered by your plan is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When can you join a Medicare Part D drug plan?

You can join a non-GIC Medicare drug plan when you first become eligible for Medicare and each subsequent year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month Special Enrollment Period to join a non-GIC Medicare drug plan.

What happens to your current coverage if you decide to join a non-GIC Medicare drug plan?

- ❑ If you enroll in another Medicare prescription drug plan or a Medicare Advantage plan with or without prescription drug coverage, you will be disenrolled from the GIC-sponsored CVS Caremark plan. If you are disenrolled from CVS Caremark, you will lose your GIC medical, prescription drug, and behavioral health coverage.
- ❑ If you are the insured and decide to join a non-GIC Medicare drug plan, both you and your covered spouse/dependents will lose your GIC medical, prescription drug, and behavioral health coverage.
- ❑ If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available online at **socialsecurity.gov** or by phone at 800-772-1213 (TTY: 800-325-0778).

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with a GIC plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage …

Contact the GIC at 617-727-2310, extension 1.

Note: You will receive this notice each year and if this coverage through the Group Insurance Commission changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage ...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ❑ Visit **medicare.gov**.
- ❑ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- ❑ Call 800-MEDICARE (800-633-4227); TTY users should call 877-486-2048.

If you have limited income and assets, extra help paying for Medicare prescription drug coverage is available. For information about the Extra Help program, visit Social Security online at **socialsecurity.gov** or call 800-772-1213 (TTY: 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- ❑ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- ❑ Service members who elect to continue their GIC health coverage are required to pay the employee's share for such coverage.
- ❑ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **866-4-USA-DOL** or visit its website at **www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **www.dol.gov/elaws/userra.htm**. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information about your GIC coverage, please contact the Group Insurance Commission at 617-727-2310, ext. 1.

Overview of Health Insurance Marketplaces

You are receiving this notice as required by the new national health reform law (also known as the Affordable Care Act or ACA).

On January 1, 2014, the Affordable Care Act (ACA) was implemented in Massachusetts and across the nation. The ACA brought many benefits to Massachusetts and its residents, helping us expand coverage to more Massachusetts residents, making it more affordable for small businesses to offer their employees healthcare, and providing additional tools to help families, individuals and businesses find affordable coverage. This notice is meant to help you understand health insurance marketplaces, which are required by the ACA to make it easier for consumers to compare health insurance plans and enroll in coverage. In Massachusetts, the state marketplace is known as the Massachusetts Health Connector. While you may or may not qualify for health insurance through the Health Connector, it may still be helpful for you to read and understand the information included here.

Overview

There is an easy way for many individuals and small businesses in Massachusetts to buy health insurance: the Massachusetts Health Connector. This notice provides some basic information about the Health Connector, and how coverage available through the Health Connector relates to any coverage that may be offered by your employer. You can find out more by visiting: **MAhealthconnector.org**, or for non-Massachusetts residents, **Healthcare.gov** or (800-318-2596; TTY: 855-889-4325).

What is the Massachusetts Health Connector?

The Health Connector is our state's health insurance marketplace. It is designed to help individuals, families, and small businesses find health insurance that meets their needs and fits their budget. The Health Connector offers "one-stop shopping" to easily find and compare private health insurance options from the state's leading health and dental insurance companies. Some individuals and families may also qualify for a new kind of tax credit that lowers their monthly premium right away, as well as cost sharing reductions that can lower out-of-pocket expenses. This new tax credit is enabled by §26B of the Internal Revenue Service (IRS) code.

Open enrollment for individuals and families to buy health insurance coverage through the Health Connector occurs every year. You can find out more by visiting **MAhealthconnector.org** or calling **877-MA ENROLL** (877-623-6765).

Can I qualify for federal and state assistance that reduces my health insurance premiums and out-of-pocket expenses through the Health Connector?

Depending on your income, you may qualify for federal and/or state tax credits and other subsidies that reduce your premiums and lower your out-of-pocket expenses if you shop through the Health Connector. You can find out more about the income criteria for qualifying for these subsidies by visiting **MAhealthconnector.org** or calling **877-MA ENROLL** (877-623-6765).

Does access to employer-based health coverage affect my eligibility for subsidized health insurance through the Health Connector?

An offer of health coverage from the Commonwealth of Massachusetts, as the employer, could affect your eligibility for these credits and subsidies through the Health Connector. If your income meets the eligibility criteria, you will qualify for credits and subsidies through the Health Connector if:

- ❑ **The Commonwealth of Massachusetts does not offer coverage to you**, or
- ❑ **The Commonwealth of Massachusetts offers you coverage, but**:
  - The coverage the Commonwealth of Massachusetts provides you (not including other family members) would require you to spend more than 9.5 percent of your household income for the year; or
  - The coverage the Commonwealth of Massachusetts provides does not meet the "minimum value" standard set by the new national health reform law (which says that the plan offered has to cover at least 60 percent of total allowed costs)

If you purchase a health plan through the Health Connector instead of accepting health coverage offered by the Commonwealth of Massachusetts please note that you will lose the employer contribution (if any) for your health insurance. Also, please note that the amount that you and your employer contribute to your employer-sponsored health insurance is often excluded from federal and state income taxes. Health Connector premiums have different tax treatment.

As part of considering whether the ACA and marketplaces will affect you as an employee it is important to understand what the Commonwealth of Massachusetts offers you.

- ❑ The Commonwealth offers benefited employees health coverage through the Group Insurance Commission. To be eligible for GIC health insurance, a state employee must work a minimum of 18¾ hours in a 37.5 hour work week or 20 hours in a 40 hour work week. The employee must contribute to a participating GIC retirement system, such as the State Board of Retirement, a municipal retirement board, the Teachers Retirement Board, the Optional Retirement Pension System for Higher Education, a Housing, Redevelopment Retirement Plan, or another Massachusetts public sector retirement system (OBRA is not such a public retirement system for this purpose). Visit **www.mass.gov/gic** or see your GIC coordinator for more information.
- ❑ Temporary employees, contractors, less-than-half time part time workers, and most seasonal employees are not eligible for GIC health insurance benefits. These employees may shop for health insurance through the Health Connector and may be eligible for advanced premium federal tax credits and/or state subsidies if their gross family income is at or below 400% federal poverty level (which is approximately $46,000 for an individual and $94,000 for a family of four). Visit **www.MAhealthconnector.org** or call **877-MA-ENROLL** for more information.

If there is any confusion around your employment status and what you are eligible for, please email **healthmarketplacenotice@massmail.state.ma.us** or contact your HR department or GIC coordinator.

Appendix B: Forms

This appendix contains the following forms:

- ❑ Fitness Club Reimbursement Form
- ❑ Bill Checker Program Form

You can download these and other forms, such as claim forms, from unicarestateplan.com.

If you don't have access to a computer, you can request forms by calling UniCare Customer Service at 800-442-9300.

Fitness Club Reimbursement Form

What information do I need to provide?

1. A completed copy of this form
2. A copy of the membership agreement with the fitness club
3. Proof of payment (at least one of the following):
   - ❑ Itemized receipts from the fitness club that shows how much you paid and for what period of time
   - ❑ Copies of receipts for fitness club membership dues
   - ❑ Credit card statement or receipts
   - ❑ Statement from fitness club showing that payment was made (statement must be on the club's letterhead and have an authorized signature)

What else do I need to know?

- ❑ See "Fitness club reimbursement" on page 44 for details about what is covered under the fitness club reimbursement benefit.
- ❑ Write your UniCare member ID number prominently on all the receipts and documents that you are sending to UniCare and keep copies of all your paperwork for your records.
- ❑ We suggest that you send proof of payment for the entire $100 instead of making several requests for lesser amounts.
- ❑ Call UniCare Customer Service at 800-442-9300 if you have any other questions.

1. Enrollee name (Last, First, MI)	**2. Enrollee address**
3. Member ID (from UniCare ID card)	
4. Enrollee birth date	**5. Member name (if different from enrollee)**
6. Name of fitness club	**7. Member's relationship to enrollee**
8. Requested reimbursement amount (up to $100) **$**	**9. Reimbursement applies to what plan year?**

Write your member ID on all paperwork. Send this form,
a copy of your fitness club membership, and proof of payment to:

UniCare State Indemnity Plan – Fitness Club Reimbursement
PO Box 9016
Andover, MA 01810

Appendices

Bill Checker Program Form

What is the Bill Checker program?

UniCare's Bill Checker program lets you share in any savings that the Plan realizes if you find errors on your medical bills.

UniCare encourages you to always review your medical bills for accuracy. If you find an error and get a corrected bill from your provider, send copies of both bills to UniCare for review. You will get 25% of any savings that result from a confirmed billing error.

What else do I need to know?

- ❑ See "Checking your claims for billing accuracy" on page 81 for details about the Bill Checker program.
- ❑ Send the completed Bill Checker form, along with copies of the original and corrected bills, to the address shown at the bottom of this page.
- ❑ Write your UniCare member ID number prominently on all the documents that you are sending to UniCare and keep copies for your own records.
- ❑ Note that duplicate claims and services are not covered by UniCare and will not be reviewed.
- ❑ Call UniCare Customer Service at 800-442-9300 if you have any other questions.

1. Enrollee ID (from UniCare ID card)	**2. Name of service provider**
3. Enrollee name (Last, First, MI)	**4. Date of service**
5. Patient name (if different from enrollee)	**6. ☐ Inpatient ☐ Outpatient**

Write your member ID on all paperwork. Send this form and copies of the original and corrected bills to:

UniCare Customer Service Center
PO Box 9016
Andover, MA 01810-0916

Appendix C: Federal and State Mandates

- ❑ Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)
- ❑ Coverage for Reconstructive Breast Surgery
- ❑ Minimum Maternity Confinement Benefits

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP program. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, or dial **877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor electronically at www.askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.
The following list of states is current as of January 31, 2016.
Contact your state for further information on eligibility.

Premium Assistance Under Medicaid and CHIP

ALABAMA – Medicaid

Website: www.myalhipp.com

Phone: 855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 888-318-8890

Phone (Anchorage): 907-269-6529

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/hcpf

Customer Contact Center: 800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/

Phone: 877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 877-438-4479

All other Medicaid
Website: http://www.indianamedicaid.com
Phone 800-403-0864

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/

Phone: 888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm

Phone: 800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 800-442-6003
TTY Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth

Phone: 800-462-1120

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/ma/

Phone: 800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 800-694-3084

NEBRASKA – Medicaid

Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx

Phone: 855-632-7633

NEVADA – Medicaid

Medicaid Website: http://dwss.nv.gov/

Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website:
http://www.njfamilycare.org/index.html

CHIP Phone: 800-701-0710

NEW YORK – Medicaid

Website:
http://www.nyhealth.gov/health_care/medicaid/

Phone: 800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 888-365-3742

OREGON – Medicaid

Website:
http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov

Phone: 800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.us/hipp

Phone: 800-692-7462

RHODE ISLAND – Medicaid

Website: www.eohhs.ri.gov

Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov

Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov

Phone: 888-828-0059

TEXAS – Medicaid

Website: https://www.gethipptexas.com/

Phone: 800-440-0493

UTAH – Medicaid and CHIP

Website:
Medicaid: http://health.utah.gov/medicaid
CHIP: http://health.utah.gov/chip

Phone: 877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/

Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premuim_assistance.cfm

Medicaid Phone: 800-432-5924

CHIP Website: http://www.coverva.org/programs_premium _assistance.cfm

CHIP Phone: 855-242-8282

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx

Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx

Phone: 877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website: http://www.dhs.wisconsin.gov/publications/p1/p10095.pdf

Phone: 800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/

Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565[1]

1 OMB Control Number 1210-0137 (expires 10/31/2016)

Coverage for Reconstructive Breast Surgery

Coverage is provided for reconstructive breast surgery as follows:

1. All stages of breast reconstruction following a mastectomy
2. Reconstruction of the other breast to produce a symmetrical appearance after mastectomy
3. Prosthetics and treatment of physical complications of all stages of mastectomy, including lymphedemas

Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts.

Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is applicable and is more generous than the federal law, your benefits will be paid in accordance with your state's law.

Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. Parent education
2. Assistance and training in breast or bottle feeding, and
3. Performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

You must notify the Plan within 24 hours – one business day – of being admitted to the hospital. Please call UniCare Customer Service at 800-442-9300 if you have questions.

Appendix D: Your Right to Appeal

This appendix describes how UniCare handles member appeals in accordance with federal regulations.

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- ❑ A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- ❑ A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- ❑ You will be provided with a written notice of the denial or rescission; and
- ❑ You are entitled to a full and fair review of the denial or rescission.

A **rescission** is a retroactive termination of coverage as a result of fraud or an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage is not a rescission if the cancellation has a prospective effect or if the cancellation is due to a failure to timely pay required premiums or contributions toward the cost of coverage.

The procedure UniCare follows satisfies the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, UniCare's notice of the adverse benefit determination (denial) will include the following, when applicable:

- ❑ Information sufficient to identify the claim involved;
- ❑ The specific reasons for the denial;
- ❑ A reference to the plan provisions on which UniCare's determination is based;
- ❑ A description of any additional material or information needed to reconsider your claim;
- ❑ An explanation of why the additional material or information is needed;
- ❑ A description of the plan's review procedures and the time limits that apply to them;
- ❑ Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination, and about your right to request a copy of it free of charge;
- ❑ Information about your right to a discussion of the claims denial decision;
- ❑ Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, and about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- ❑ The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- ❑ UniCare's notice will also include a description of the applicable urgent/concurrent review process; and
- ❑ UniCare may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination. You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. UniCare's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

UniCare shall offer an appeals process and an external review process. In cases involving eligibility for coverage, you may only appeal; there is no external review. The time frame allowed for UniCare to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care

You may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including UniCare's decision, can be exchanged by telephone, fax, or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact UniCare at the number shown on your blue UniCare ID card and provide at least the following information:

- ❑ The identity of the claimant;
- ❑ The dates of the medical service;
- ❑ The specific medical condition or symptom;
- ❑ The provider's name;
- ❑ The service or supply for which approval of benefits was sought; and
- ❑ Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals

All other requests for appeals should be submitted in writing by the member or the member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., urgent care). You or your authorized representative must submit a request for review to:

UniCare State Indemnity Plan
P.O. Box 2011
Andover, MA 01810

Upon request, UniCare will provide reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- ❑ Was relied on in making the benefit determination; or
- ❑ Was submitted, considered, or produced in the course of making the benefit determination; or
- ❑ Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- ❑ Is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

UniCare will also provide you with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination based on a new or additional rationale, UniCare will provide you with the rationale.

How Your Appeal Will Be Decided

When UniCare considers your appeal, it will not rely upon the initial benefit determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care

UniCare will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim

UniCare will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim

UniCare will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from UniCare will include all pertinent information set forth in "Notice of Adverse Benefit Determination" on page 164.

External Review

If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law.

Unless you are filing an expedited external review, you must first file an appeal with UniCare before you can pursue an external review. You must submit your request for external review to UniCare within four months of the notice of UniCare's adverse determination of your appeal.

A request for an external review must be in writing unless UniCare determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for your appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an appeal or while simultaneously pursuing an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including UniCare's decision, can be exchanged by telephone, fax, or other similar method.

To proceed with an expedited external review, you or your authorized representative must contact UniCare at the number shown on your blue UniCare ID card and provide at least the following information:

- ❑ The identity of the claimant;
- ❑ The dates of the medical service;
- ❑ The specific medical condition or symptom;
- ❑ The provider's name;
- ❑ The service or supply for which approval of benefits was sought; and
- ❑ Any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless UniCare determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

UniCare State Indemnity Plan
P.O. Box 2011
Andover, MA 01810

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this health care plan. The external review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to File an Appeal before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's appeals process before filing a lawsuit or taking other legal action of any kind against the Plan.

We reserve the right to modify the policies, procedures and time frames in this section upon further clarification from the Department of Health and Human Services and the Department of Labor.

Index

The pages shown in boldface have the most complete information.

0-9

24/7 NurseLine.....3, 96, **99**

A

Acne-related services.....**68**
Acupuncture.....**68**
Adverse benefit determination.....see *Appeals*
AIM Specialty Health.....**15**
Air conditioners.....**73**
Allowed amount.....**25**, 101
Ambulance services.....28, **33**, 68
Ambulatory surgery centers.....**101**
Ancillary services.....**50**
Anesthesia.....**33**, 68
Appeals ..... 83, 101, **Appendix D**
Arch supports.....**68**
Assistant surgeons.....**60-61**, 68
Athletic trainers.....**68**
Attempt, definition of.....**49**
Audiology services.....see *Hearing exams*
Autism spectrum disorders **33**
.....also see *Behavioral health services*

B

Balance billing.....**26-27**, 101
Beacon Health Options 3, 12, 96, **123-147**
Beds **68**, 72
Behavioral health, definition of **33**, 101
Behavioral health services 28, 33, 68, **123-147**
Benefits summary ..... see *Summary of benefits*
Bereavement counseling .....see *Hospice care*
Bill checker program.....**81**, 159
Birth control..... see *Family planning*
Blood donations **69**
Blood pressure cuff.....**69**
Bone density testing.....**66**
BPAP and CPAP equipment.....**16**, 40
Braces.....see *Orthotics*
BRCA testing.....16, **64**
Breast cancer
  prosthetics.....**57**
  screening.....16, **64**
  surgery **60**, 163

C

Calendar quarter, definition of **22**
Cardiac rehabilitation 28, **34**
Case management.....**84**
CAT scans ..... see *High-tech imaging*
Cataracts..... see *Eye care*
Centered Care Initiative **76**
Chair cars / vans **69**
Checkups **64-67**
Chemotherapy 28, **34**
Children's Health Insurance Program
  (CHIP)..... **160-162**
Chiropractic care 16, 24, 28, **34**, 71
Cholesterol screening **65**
Chronic disease facilities
  ..... see *Other inpatient facilities*
CIC **12**, 101
Circumcision **35**
Claims
  checking accuracy.....**81**
  checking claim status.....**100**
  claims review.....**82**
  deadline for filing **80**
  denial of.....**83**, Appendix D
  legal action.....**82**
  requesting a review.....**100**
  submitting **80**
Cleft lip / cleft palate.....16, **35**
Clinical trials **35-37**, 69
Clinics .....see *Medical clinics*
COB.....see *Coordination of Benefits*
COBRA **88-91**
Cognitive therapy **69**
Coinsurance.....**25**, 101
Colonography.....see *Virtual colonoscopies*
Colonoscopies 16, **65**, 69

Commodes **73**
Comprehensive Insurance Coverage .....see *CIC*
Computer-assisted communications devices ... **69**
Contact information **3**, 96
Contact lenses .....see *Eyeglasses*
Continued stay review **51**
Coordination of Benefits (COB)..... **93-95**
Copays **22-24**, 101
Cosmetic services **69**, 101
Costs ..... see *Member costs*
Coverage information **85-95**
  application for coverage **85**
  COBRA **88-91**
  continuing **86-87**
  conversion to non-group coverage **92**
  special enrollment condition **86**
Craniosacral therapy ....see *Manipulative therapy*
CT scans ..... see *High-tech imaging*
Custodial care **69**, 101
Customer Service Center 3, 14, 96, **97**
CVS Caremark..... 3, 12, 96, **107-121**

D

Deductible..... **21**, 101
Definitions of terms **101-105**
Dental services..... **37**, 69
Dentures..... **69**
Dependent, definition of **102**
Designated hospitals **63**
Diabetes care **37-38**, 65
Diabetes supplies 28, **38**
Diagnostic lab tests..... see *Laboratory services*
Dialysis 28, **39**
Dietary counseling..... see *Nutritional counseling*
Disclosure when plan
  meets minimum standards **2**
Divorce **87**
Doctor services 28, **39**
Documents .....see *Plan materials*
Driving evaluations **69**
Drugs ..... see *Prescription drugs*
Durable medical equipment (DME)
  ..... 16, 28, **40-41**, 46, 73

E

EAP (Enrollee Assistance Program)..... **123-147**
Ear molds..... **70**
Early intervention programs 29, **41**
Echocardiography **16**
EKG (electrocardiogram)..... **70**
Elective services 17, **102**
Eligibility .....see *Coverage information*
Email consultations..... **70**
Emergency, definition of **41**
Emergency room services 17, 24, 29, **41-42**
End-stage renal disease (ESRD) **95**
Enrollee, definition of **102**
Enrollment .....see *Coverage information*
Enteral therapy 16, **42**, 70
Excluded services **68-74**
Experimental procedures **70**, 71, 102
Eye care..... 24, 29, **42-43**, 67, 71, 74
Eyeglasses 29, **43**, 70

F

Family planning 29, **43**
Filing deadline .....see *Claims*
Fitness reimbursement 29, **44**, 70, 158
Foot care **44**, 68
Forms ..... **Appendix B**
Free or low-cost coverage 70, **85**

G

Gender reassignment surgery..... **16**
GIC privacy practices ..... see *Privacy rights*
Grievance, definition of **102**
Gyms ..... see *Fitness reimbursement*
Gynecology exams..... **45**, 64, 65

H

Health Connector **155-156**
Hearing aids 29, **45**
Hearing exams 29, **45**, 65
High-tech imaging 17, 24, **58**
HIPAA ..... see *Privacy rights*
Hippotherapy **71**
Home construction **71**
Home health care 17, 29, **46**
Home infusion therapy..... 29, **47**
Hospice care..... 29, **47-48**
Hospital, inpatient
  ..... see *Inpatient care at hospitals*
Hospitals **77,** 102
Hyperbaric oxygen..... see *Oxygen*

I

ID cards **13-14**
Imaging ..... see *Radiology services*
Immunizations 63, **66**, 71
IMRT **18**, 58
Incontinence supplies **71**
Infertility treatment **48-49**, 71
Injury, definition of **103**
Inpatient care at hospitals
..... 17, 22, 24, 30, **50-51**, 102
Inpatient care at other facilities 30, **52**
Insurance, other **13**
Internet services **74**
Interpreting services **2**
In vitro fertilization ..... see *Infertility treatment*

L

Laboratory services 30, **52**, 67
Language interpreter ..... see *Interpreting services*
Legal action **82**
Lenses, intraocular **71**
Lift chairs **71**
Limited services **68-74**
Long-term care **71**
Long-term care facilities
..... see *Other inpatient facilities*
Low-cost coverage
..... see *Free or low-cost coverage*

M

Mammograms **64**
Manipulative therapy 16, **56**, 71
Marketplaces, health care **155-156**
Massachusetts providers ..... see *Providers*
Massage **72**
Maternity benefits 17, **53**, 163
Mattresses, orthopedic **72**
Medical clinics 24, 30, **53**, 75, 77
Medical necessity 72, **103**
Medical services, other 30, **53**
Medical supplies **103**
Medicare
Coordination of Benefits (COB) **94**
and prescription drugs **152-154**
Member costs **20-27**, 75-76, 99
Member, definition of **103**
Mental health services
..... see *Behavioral health services*
Molding helmets **72**
MRIs ..... see *High-tech imaging*

N

Network, definition of **103**
Network providers ..... see *Providers*
Non-CIC ..... see *CIC*
Non-Massachusetts providers ..... see *Providers*
Non-Massachusetts residents **14**, 26, 75
Notice of privacy practices ..... see *Privacy rights*
Notification requirements **14-19**, 76
Nurse practitioners ..... see *Providers*
Nursing homes, definition of **103**
NurseLine ..... see *24/7 NurseLine*
Nutritional counseling **54**, 65, 72
Nutritional supplements **72**

O

Occupational injury **74**
Occupational therapy 17, 24, 30, **54**, 71
Office visits 23, 30, **39**
Online access to plan information **98**
Organ donors **62**
Orthodontic treatment **72**
Orthotics 31, **57-58**, 72
Osteopathic care ..... see *Chiropractic care*
Other health insurance **13**
Other inpatient facilities 30, **52**, 104, 105
Out-of-pocket limits **25**, 104
Out-of-state dependents **75**
Out-of-state providers ..... see *Providers*
Outpatient services 23, 24, 30, **54**
Outpatient surgery 23, 24, 32, **60-61**, 75
Oxygen 17, 31, 40, **55**, 72

P

Palliative care **55**
Pap smear 45, **64**
Patient-Centered Primary Care **76**
PCPs (primary care providers) ..... see *Providers*
Personal comfort items **73**
Personal Emergency
Response Systems (PERS) 31, **55**
PET scans ..... see *High-tech imaging*
Physical therapy 17, 24, 31, **56**, 71
Physician assistants ..... see *Providers*
Physician, definition of **104**

Physician services ..... see *Doctor services*
Physician tiering 75, **78-79**, 105
Plan definitions **101-105**
Plan materials **99**
Plan year, definition of **20**
Post-delivery care, home **163**
Preferred vendors **27**, 75, 77, 103, 104
Prescription drugs
  coverage for 31, 56, 69, **107-121**
  and Medicare **152-154**
  specialty drugs **18**, 69
Pre-service review 14, **83**
Preventable adverse health events **73**
Preventive care 31, 56, **64-67**
Primary care providers (PCPs) ..... see *Providers*
Privacy rights 82, **150-152**
Private duty nursing 17, 31, **57**, 73
Private room **50**
Prosthetics 31, **57-58**
Providers
  finding **78**, 98
  in Massachusetts **14**, 26, 75
  network 14, 26, 75, **78**, 103
  nurse practitioners **104**
  outside of Massachusetts **14**, 26, 75
  PCPs 24, **76**
  physician assistants **104**
  reimbursement of **80**
  services 28, **39**
  specialists 24, **77**
  Travel Access 26, 75, **78**
  types of **76-78**
PSA test **67**

Q

Qualified clinical trials ..... see *Clinical trials*
Quality Centers for transplants
  ..... see *Designated hospitals*
Quarter ..... see *Calendar quarter*

R

Radiation therapy 18, 31, **58**
Radioactive isotope therapy **58**
Radiology services 31, **58**
Reconsideration (after a denial) **83**
Reconstructive surgery **61**, 163
Rehabilitation services, definition of **104**
Release of medical information **100**
Religious facilities, use of **73**
Rescission, definition of **164**
Respite care **47**, 73
Retail medical clinics ..... see *Medical clinics*
Reviews of medical services 14, **83**
Right of recovery **94**
Right of reimbursement **82**
Routine screenings **73**

S

Sensory integration therapy **73**
Shower chairs **73**
Skilled care, definition of **104**
Skilled nursing facilities
  ..... see *Other inpatient facilities*
Sleep studies 18, **59**
SmartShopper ..... see *Vitals SmartShopper*
Smoking ..... see *Tobacco cessation*
Special enrollment condition **86**
Specialists ..... see *Providers*
Specialized health facilities 77
Specialty drugs ..... see *Prescription drugs*
SPECT scans ..... see *High-tech imaging*
Speech therapy 31, **59**, 71
Spouse, definition of **105**
Stairway lifts / ramps **73**
Students 75, **87**
Sub-acute care facilities
  ..... see *Other inpatient facilities*
Substance use disorder services
  ..... see *Behavioral health services*
Summary of benefits **28-32**
Surface electromyography (SEMG) **73**
Surgery 18-19, 23, 32, **60-61**
Surrogates **71**
Symbols, in handbook **13**

T

Telecommunications device for the
  deaf (TDD) **3**
Telehealth **73**
Telephone consultations **73**
Telephone numbers, important **3**
Terminal illness, definition of **47**
Thermal therapy devices **73**
Tiering ..... see *Physician tiering*
TMJ disorder **74**
Tobacco cessation 32, **61-62**, 67, 74
Transitional care facilities
  ..... see *Other inpatient facilities*

Translating services .....see *Interpreting services*
Transplants.....19, 32, **62-63**
Travel.....**26**, 74, 75
Travel Access providers..... see *Providers*
Travel clinics.....**63**

U

unicarestateplan.com.....**98-99**
UniCare Customer Service Center...3, 14, 96, **97**
Urgent care.....**53**, 75
Urgent care centers ..... see *Medical clinics*
USERRA (Uniformed Services Employment and Reemployment Rights Act).....**154-155**

V

Varicose vein treatment **19**
Virtual colonoscopies.....**16**, 65
Vision care .....see *Eye care*
Visiting Nurse Associations (VNA).....**46**
Vitals SmartShopper **99**
Voice therapy **74**

W

Walk-in clinics ..... see *Medical clinics*
Website..... see *unicarestateplan.com*
Weight loss programs.....**74**
Whirlpools.....**73**
Wigs **63**, 74
Workers compensation.....**74**
Worksite evaluations.....**74**

X

X-rays ..... see *Radiology services*

UniCare State Indemnity Plan
P.O. Box 9016
Andover, MA 01810-0916
800-442-9300
unicarestateplan.com

58614MAMENUNC 06/16